CHAPTER 16:

Family Planning, Maternal Health, 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 healthcare resources as well as to assist 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, vision, dental, hearing, and all other medically necessary mandatory and optional services listed in Federal Law 42 USC 1396d to correct or ameliorate defects, physical and behavioral illnesses, and conditions identified in the EPSDT screening, whether 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 the 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 Clinical Sample Templates, 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 Clinical Sample Templates 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, vision, dental, hearing, 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 those 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 30 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 if 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, naturopathic services, and nurse practitioner services
- Medications
- Dental services
- Therapy services
- Behavioral health services
- Medical equipment, medical appliances, and medical supplies
- Orthotics
- Prosthetic devices
- Eyeglasses including replacement
- Transportation
- Family planning services and supplies
- Women’s preventive care services, and maternity services when applicable, as specified in AMPM Chapter 400

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 BCBSAZ Health Choice 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 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 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 30 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 and the AHCCCS Dental Periodicity Schedule. Inter-periodic screenings should be performed as appropriate for each member. The Contractor 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 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.
3. Nutritional Assessment - 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 is included in the EPSDT visit and is a separately billable service.

4. Behavioral Health Screening and Services – We cover behavioral health services for members eligible for EPSDT. PCPs may provide behavioral health services to eligible EPSDT members within their scope of practice as specified in AMPM Policy 510. American Indian/Alaska Native members may receive behavioral health services through an Indian Health Service or tribally owned and/or operated 638 facilities regardless of health plan enrollment or behavioral health assignment. PCPs who 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 by the PCP at each EPSDT visit.

   The following Behavioral Health Screenings are separately billable, and a copy kept in the member's medical record, refer to the Medical Coding page on the AHCCCS website.
   - Postpartum consisting of a standard norm-criterion referenced screening tool to be performed for screening the birthing parent for signs and symptoms of postpartum depression during the one-, two-, four- and six-month EPSDT visits. Positive screening results require referral to appropriate case managers and services at the respective maternal health plan, and
   - Adolescent Suicide consisting of a standardized, norm-referenced screening tool specific for suicide and depression shall be performed at annual EPSDT visits beginning at age 10 years of age. Positive screening results require appropriate and timely referral for further evaluation and service provision.

   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 – Accepted developmental screening tools are described in the CMS Core Measure Developmental Screening in the First Three Years of Life and 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 (AAP). The general developmental screening should be completed for EPSDT members during the 9th month, 18th month and 30th month EPSDT visits. In addition, autism spectrum disorder (ASD) specific developmental screening should occur at the 18 months and 24 months EPSDT visits. A copy of the screening tool must be kept in the medical record. Use of accepted developmental screening tools as described in the CMS Core Measure *Developmental Screening in the First Three Years of Life 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 30th 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 30-month EPSDT visit, and an accepted developmental screening tool must have been completed.

For (ASD) specific developmental screening, the provider must use the accepted tools as described in the CMS Core Measure Developmental Screening in the First Three Years of Life (DEV) Measure Specifications.

6. Appropriate immunizations for members under the age of 19 years, according to age and health history, as specified in the CDC recommended childhood immunization schedules and as specified in AMPM Policy 310-M (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.

   Providers may also provide COVID-19 vaccine counseling whether the vaccine counseling occurs in conjunction with a preventive health visit (e.g., EPSDT), in conjunction with an office visit when another service was provided (e.g., office visit to address diagnosed illness(es), new issues, and/or prescription refills), or when COVID-19 vaccine counseling is the sole reason for the office visit.
7. Laboratory tests
   - Laboratory including 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 all members at 12 months and 24 months of age and for those members between the age of 24 months through six years who have not been previously tested or who missed either the 12 month or 24 months test. Lead levels may be measured at times other than those specified if thought to be medically indicated by the provider, by responses to a lead poisoning verbal risk assessment, or in response to guardian/Health Care Decision Maker (HCDM), Designated Representative (DR)s concerns. Additional screening for children through six years of age is 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.

     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.

8. Health education, counseling, and chronic disease self-management are not separately billable services and are considered part of the EPSDT visit payment.
9. Appropriate oral health screening, intended to identify oral pathology, including tooth decay and/or oral lesions, and the application of fluoride varnish conducted by a physician, nurse practitioner, or physician assistant. 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 three 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 five years of age. Application of fluoride varnish by the PCP does not take the place of a visit at the dental home.
10. Appropriate vision screenings and services 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 separately billable services.

Ocular photo screening with interpretation and report, bilateral (CPT code 99177) is covered for children age's three through 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. Except for CPT code 99177, no additional reimbursement is allowed for these codes.

11. Appropriate Hearing Screening and Services. 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. Except for 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 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 Clinical Sample Templates must be used to document services provided and comply with AHCCCS standards. The EPSDT Templates 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 the components found on the AHCCCS EPSDT Clinical Sample Templates. A copy of the electronic medical record may be sent to us in lieu of the current AHCCCS EPSDT Clinical Sample Templates.

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

- **Breastfeeding Support** - Providers must ensure families receive evidence-based **breastfeeding** information and support, per AAP recommendation.
- **Immunizations** - EPSDT covers all child and adolescent immunizations as specified in the Centers for Disease Control and Prevention (CDC) recommended childhood immunization schedules and AMPM Policy 310-M. 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.azdhs.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. 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 reenroll annually with the VFC program, in accordance with AHCCCS Contract requirements.

  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. We are 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 and other services, including replacement and repair of eyeglasses, 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. As part of EPSDT, eyeglasses and other vision services, including replacement and repair of eyeglasses, for members under the age of 21 years are covered, **without restrictions**, by BCBSAZ Health Choice to correct or ameliorate conditions discovered during vision screenings for EPSDT.

- **Blood Lead Screening** - EPSDT covers blood lead screening and testing appropriate to age and risk. Blood lead testing is required for all members at 12 months and 24 months of age and for those members between the ages of 24 through six years who have not been previously tested or who missed either the 12-month or 24-month test. Lead levels may be measured at times other than those specified if thought to be medically indicated by the provider, by responses to a lead poisoning verbal risk assessment or response to parental concerns. Additional screening for children through 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.

  In-office capillary blood draws utilizing validated CLIA waived testing equipment are covered for in-network point of care EPSDT visits. A blood lead test result equal to or greater than the current CDC recommended blood lead reference values obtained by capillary specimen or fingerstick must be confirmed using a venous blood sample. The ADHS Parent Questionnaire may be utilized to help determine if a lead test should be performed outside of the required testing ages. Screening efforts should focus on assuring that these children receive blood lead testing. Anticipatory guidance to provide an environment safe from lead, should be included as part of each EPSDT visit from six months through six years of age. Providers must report all blood lead levels to Arizona Department of Health Services as required under (A.A.C. R9-4-302). We provide care coordination for members with elevated blood lead level and are transitioning to or from another AHCCCS Contractor.

  We track all elevated blood lead levels. These levels are monitored monthly when we receive the most recent results from the ADHS EBLL report. We contact members with elevated blood lead levels. The families are encouraged to seek retesting at the appropriate times.
- **Organ and Tissue Transplantation Services** – Note: Please refer to the AHCCCS Medical Policy Manual, Chapter 300, Policy 310-DD 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** - Nutritional assessments are conducted to assist EPSDT members whose health status may improve with nutrition intervention. We cover 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. The Plan 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.

If a member qualifies for nutritional therapy due to a medical condition, the following is covered:

- For medically necessary WIC-exempt formula
- Refer to Arizona WIC program food list,
- For medically necessary WIC-exempt formula, we are responsible for procurement of and the primary payor for any other nutritional supplementation that is medically necessary,
- For medically necessary WIC-exempt formula, the provider is also responsible for

procurement of any other nutritional supplementation that is medically necessary.

- **Metabolic Medical Foods**- 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 foods, and Total Parenteral Nutrition
- **Nutritional Therapy**- We cover nutritional therapy for EPSDT eligible members on an Enteral Nutrition, TPN, 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.
- Aveanna is the contracted service provider for Enteral Therapy services. Requests for Enterals and their DME (pumps, poles, syringes, bag systems, etc.) are to be sent to the Plan. Medical records documenting the medical necessity of the request must also be provided in addition to a current, signed provider order(s)/prescription. We will process the request and forward to Aveanna who will coordinate with the requesting provider and/or member as needed to ensure delivery.
- Submit the request to our Provider Portal or the Prior Authorization fax number: 1-877-422-8120.
    - 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 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

(b) 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 can consume no more than 25% of his/her nutritional requirements from age-appropriate food sources

(c) 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. This documentation must demonstrate that the member meets all the required criteria and includes:
  - Initial Requests
    a. Documentation demonstrating 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 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 (BMI if member is two years of age or older, otherwise evidence that the World Health Organization's (WHO) growth charts were used per CDC and AAP guidance for children under age two).
    c. Documentation detailing alternatives that were tried 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:

- Documents are submitted with the completed Certificate of Medical Necessity to support all the necessary requirements for Commercial Oral Nutritional Supplements as detailed above.
- If the member's parent, guardian, or Health Care Decision Maker (HCDM), Designated Representative (DR) 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.
- 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.
- 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 a member is transitioning from BCBSAZ Health Choice 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 provider 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 Osseo Integrated 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 post lingual. We cover medically necessary services for cochlear implantation for EPSDT members only.

Cochlear implantation is limited to one (1) functioning implant per member. We 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 either unilateral or 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
- 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 Prior Authorization.
    - **Osseo integrated implants (bone anchored hearing aid [BAHA]** – We cover medically necessary services for osseo integrated implantation is limited to EPSDT members. 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. Osseo integrated implant requires Prior Authorization
- **Conscious Sedation** – We cover conscious sedation for members receiving EPSDT services. 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

We will consider conscious sedation for other procedures on a case-by-case basis.

- **Behavioral Health Services** – We cover 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 the services are covered under the AHCCCS State Plan. Please refer to the AHCCCS clinical guidelines 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, we 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). BCBSAZ Health Choice conducts biannual 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** – We cover religious non-medical health care institution services for members eligible for EPSDT services as described in AMPM Chapter 1200, Policy 1210.
- **Care Management Services** – We provide 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. (NCQA HPA 2024, PHM 5C: 1-17)
- **Chiropractic Services** – We cover chiropractic services to members eligible for EPSDT services when ordered by the member's PCP and approved by us to ameliorate the member's medical condition.
- **Personal Care Services** – We cover personal care services, as appropriate, for members eligible for EPSDT services.
- **Incontinence Briefs** – Incontinence briefs, including pull-ups and incontinence pads, are covered 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 us
- **Medically Necessary Therapies** –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 are covered. 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 visit 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 an EPSDT visit are not to be considered when determining the level of the additional service (CPT Code 99201-99215).

- The 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 a significant, separately identifiable evaluation and management service was provided by the same provider 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: In accordance with AHCCCS and federal requirements, the Plan 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) 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. We pay an administration fee for each VFC antigen administered to a member. We can't use 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): https://www.azdhs.gov/preparedness/epidemiology-disease-control/immunization/index.php#vaccines-children-home 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 19. 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 https://asiis.azdhs.gov/

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. The Plan 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 HCHEPSDTChec@azblue.com
- Completing standard EPSDT Clinical Sample Templates or equivalent forms, during every EPSDT visit
- Placing copies of the EPSDT forms or equivalent EHRs 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 Clinical Sample Templates or equivalent forms and developmental screening tool, as appropriate, to the BCBSAZ Health Choice EPSDT Coordinator Fax (480) 760-4716 or email HCHEPSDTChec@azblue.com
- The EPSDT forms should be forwarded on a daily or weekly basis to ensure timely processing.

Please do not submit EPSDT forms or developmental screening tool copies to AHCCCS Administration

AHCCCS EPSDT Clinical Sample Templates can be downloaded from the AHCCCS web site at https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/400/430_AttachmentE.doc

Or

EPSDT Clinical Sample Templates can be ordered from the EPSDT Department. Fax the EPSDT Clinical Sample Templates Order Sheet to (480) 760-4716, or email HCHEPSDTChec@azblue.com

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-A) 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. We provide care management services for referred children to ensure appropriate support services are implemented.

General Eligibility for Children's Rehabilitative Services (CRS)

- 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

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/guardian, HCDM, DR and developmental screening tools.
- If the PCP identifies potential developmental delays, the PCP should request an evaluation and possible service authorization from us for a specialist.
- PCP must submit the clinical information supporting the request for evaluation and service authorization to us.

- 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, the Plan 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 fax the" AzEIP AHCCCS Member Service Request form" and copies of the evaluation/developmental summaries completed during the IFSP process to our Medical Prior Authorization Department fax at (480)760-4993 within 2 business days of completing the IFSP.
4. We will enter the AzEIP Member Service request into the prior authorization system within 1 business day of receipt of the request.
5. We forward the documentation to the PCP within 2 business days. (NCQA HPA 2024, UM6 A) 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.
6. Within 10 business days from the date, we forward 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 fax the form back to us at (602) 829-3250 along with a script (s), and medical records that support the medical necessity for services.
7. Within 2 business days, we will notify the PCP, service provider and AzEIP Service Coordinator of the authorization determination
8. We 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. (NCQA HPA 2024, UM7 A, B:1-3)
9. 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.
10. 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. (NCQA HPA 2024, PHM 5 E:2,3,5)

11. After the member is examined by the PCP and a determination is made, steps 1 through 8 should be followed.

We encourage providers to refer children 0-3 years of age with developmental disabilities to AzEIP. AzEIP and BCBSAZ Health Choice will coordinate services for EPSDT members who are eligible for and enrolled in both AzEIP and Medicaid. We will act as the liaison between the provider, AzEIP and the servicing agency to coordinate medically necessary services for the member. We provide pediatric care management services to assist with care coordination needs.

To initiate the referral process, contact AzEIP directly at (888) 592-0140 or via the AzEIP website at https://des.az.gov/services/disabilities/developmental-infant

Please note we 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 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 Member Services at (800) 322- 8670 to arrange medically necessary transportation.

16.5 FAMILY PLANNING SERVICES

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.

Primary Care Providers (PCPs) and Primary Care Obstetricians must record annually in the member's medical records that each member of reproductive age (12 through 55 years of age) regardless of gender 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)
    - Immediate Postpartum Long-Acting Reversible Contraceptive (IPLARC)
    - Post-coital emergency oral contraceptive within 72 hours after unprotected sexual intercourse
- Screening, Counseling, and Treatment for Sexually Transmitted Infections for members regardless of gender
- Treatment of complications resulting from contraceptive use
- Sterilization regardless of gender for members who are at least 21 years of age (refer to consent form requirements as specified in 42 CFR 441.250)
- 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)

We reimburse LARC and IPLARC (Immediate Postpartum Long-Acting Reversible Contraception) services through regular claims process submitted on a 1500 claim form. We 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 indicating the risk and benefits to the member and 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: The 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 regardless of gender. There is no cost for medically necessary transportation to and from appointments. If a member needs a ride to their appointment, they can call 602-386-2447 at least three (3) days before their appointment.

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 website and the AHCCCS website and through Arizona 211. We recognize 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 at 1.800.322.8670 (TTY:711) 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 and counseling

- Immunizations
- Physical examinations
- Depression screening
- Interpersonal and domestic violence screening
- Family planning counseling

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

- Reproductive history and sexual practices
- Healthy weight, including diet and nutrition, as well as the use of nutritional supplements and folic acid intake
- Physical activity or exercise
- Oral health care
- Chronic disease management
- Emotional wellness
- Tobacco and substance use (caffeine, alcohol, marijuana, and other drugs), including prescription drug use
- Recommended intervals between pregnancies
- **NOTE:** Preconception counseling does not include genetic testing.

Screening and counseling are included as part of the well-woman preventive care visit and is focused on the benefits of preventive health by maintaining a healthy lifestyle and reducing harmful risks, which can affect both mother and newborn. The following are addressed during the well-woman preventive care appointment, at a minimum:

- Proper nutrition
- Physical activity
- Elevated BMI indicative of obesity
- Tobacco/substance use, abuse and/or dependency, including prescription-controlled substances, and counseling
- Depression screening
- Interpersonal and domestic violence screening that includes counseling involving elicitation of information from women and adolescents about current/past violence and abuse, in a culturally sensitive and supportive manner to address current health concerns about safety and other current or future health problems,
- Sexually transmitted infections
- Human Immunodeficiency Virus (HIV), counseling, and referral to a specialty provider for treatment of positive results
- 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.

We monitor provider compliance with providing well-woman preventive care services through medical record audit. Random charts are audited to ensure well-woman preventive care services are being performed according to our 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 the Plan's provider case file.

16.9 STERILIZATION

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

- They are 21 years or older
- Has 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
- 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 only requires 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

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 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
- Advise the sterilization procedure is 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 due to 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 suitable to ensure 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 considered 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 the member's state of awareness

16.10 OBSTETRICAL SERVICES

We emphasize the critical importance of prenatal health care. The Maternal Child Health Department assists obstetrical members by facilitating access to community services and programs for pregnant women. 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. We have staff available to assist you with any needs you may have.

Member's Choice of PCO

A member who is known to be pregnant will choose a Primary Care Obstetrician provider (PCO). The PCO serves as the member's Primary Care Provider throughout the course of pregnancy and up to 84 days postpartum. The PCO should provide at least one (1) postpartum follow up visit for a vaginal delivery and at least two (2) postpartum follow up visits following a Cesarean section. We encourage the PCO to see members between 7-84 days post-delivery. Services as a PCO 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 us of each pregnant woman at the beginning of her prenatal care (initial visit) by faxing a completed Maternal Health Risk Assessment form to (480) 760-4762. This Risk Assessment form is a critical component of coordinating care between the Plan 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 if all of the requested information is included in the notes. The Maternal Risk Assessment form and clinical documentation are reviewed by the maternal team to identify high risk conditions. High risk pregnant members are outreached for engagement in our maternal care management program which provides member specific, linguistically, and culturally sensitive education, referral(s) to community resources, and facilitates care coordination during the prenatal and postpartum period.

Education for Pregnant Women

During your patient's pregnancy, be sure to document all education done by you and your staff. Important topics to discuss with your patients include physiology of pregnancy, labor and delivery process, natural methods and medications used to manage pain during labor and delivery, warning signs during pregnancy, proper nutrition, access to nutritional food resources, breast feeding, screening for sexual transmitted infections, HIV screening, dangers of lead exposure, smoking cessation, drug and alcohol avoidance, depression and postpartum depression, family planning options, social determinants of health, such as housing, domestic violence, and health literacy. 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 and Medication Assisted Therapy (MAT) as indicated for substance use disorder (SUD) assessment and treatment.

OB Ultrasound:

Primary Care Obstetricians complete one to two ultrasounds on average during the prenatal period. Please submit a claim for completed Level I OB ultrasounds. CPT codes that can be used as routine OB ultrasounds are 76801, 76805, 76815. Level II ultrasounds are performed by Maternal Fetal Medicine specialists.

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 must refer the member out), and for services related to pregnancy (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 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. 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 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. We monitor appointment availability through various means. Providers who do not meet the AHCCCS standard may have a limit/cap disallowing new members.

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 during a postpartum visit. If the screening indicates, 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 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 Care Management Department by calling the Stork Line at 800 828-7514 for outreach and care management engagement. If a member has a significant behavioral health concern impacting the

pregnancy, the OB Care Manager will work collaboratively with a behavioral health care manager to ensure the member receives all needed services to have a healthy pregnancy and baby.

EPSDT Services for Pregnant Members

At the initial OB visit, the PCO will complete a Maternal Risk Assessment on all pregnant members 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 services are identified earlier in the chapter.

Laboratory Services for Pregnant Members

Laboratory services for pregnant members must be referred to our contracted laboratories unless otherwise noted on the Provider 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 Pregnant Members

ACOG recommends 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. Information on where to access treatment for a positive HIV test should also be provided. Documentation in the medical record of member refusal is required.

Reporting Non-Compliant High Risk Pregnant Members

PCOs are encouraged to notify our 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 four-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 department/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
- Has one or more social determinants affecting her health

PCOs are also encouraged to contact OB Care Management regarding any member identified as "High-Risk". We follow 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 psychological, emotional, education or physical support needs
- Non-adherent behaviors
- Current preterm labor
- Hypertension, PIH
- Preeclampsia
- Diabetes, GDM
- Premature or preterm rupture of membranes
- Homeless
- Reoccurring sexually transmitted infections
- HIV
- Substance abuse
- Domestic violence

We are 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 Maternal Health Care Management Department.

StorkLine

Our StorkLine was developed as a direct telephone line allowing members and providers access to the 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 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 the Maternal Child Health Department within 12 hours of a child’s birth. Arizona Newborn Notification forms (see

Exhibit 16.4) should be faxed to **(480) 760-4867.** We report 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 identify a fetus at risk for medical conditions which 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 BCBSAZ Health Choice covered service.

Pregnancy Terminations

Based on AHCCCS rules and regulations, we cover 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 a pregnancy termination is 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 on the AHCCCS website Chapter 400 Policy 410 Attachment C or by calling the Maternal Health Department at (800) 828-7514.

Cases of Incest, Rape, or Incapacitated Adult

(Note: subject to change as Arizona appeals court considers the current case)

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 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 and filed in the member's medical record. 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/Health Care Decision Maker (HCDM) is required

Medical Emergencies

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

The Use of Medications to End Pregnancy

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

When medications are administered, the following documentation is also required:

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

Pregnancy termination by surgery is recommended in cases when medications are used and fail to induce termination of the pregnancy.

Billing and Reimbursement

Providers can submit a claim for each prenatal/postpartum service/visit, quarterly, or at the end of service. We reimburse the provider via the contractual agreement. Financial reimbursement to any physician covering for the PCO is a decision between the two physicians involved. We are not responsible for payment to any other providers besides the member's assigned PCO. Arrangements should be made in advance with your covering providers.

Medical Record Review

We conduct medical record reviews systematically on all contracted Obstetricians/Gynecologists to ensure compliance with AHCCCS requirements and contractual agreements. Providers will

receive a letter outlining their audit results. All audit results are reviewed by the Quality Management Committee.