

SECTION E COVERED SERVICES

As an AHCCCS contracted health plan, the covered services provided by Phoenix Health Plan (PHP) are mandated by federal and state law. The following list is a summary of covered and non-covered services. To be covered, all services must be determined to be medically necessary. In addition, some services require prior authorization. *Note: Members identified as FPS have only family planning benefits.*

COVERED SERVICES

This list is intended to provide basic information and is not intended to be a restricted source of PHP medical benefits.

- Formulary medications and prior authorization medications meeting criteria filled at a participating pharmacy
- Dental routine and emergent care for members age 20 and younger
- Dentures when medically necessary for members age 20 and younger
- Emergency dental care **ONLY** for members 21 and older when service is provided in accordance with AHCCCS rules and regulations (*Refer to Section H*)
- 24-Hour emergency services
- Family Planning, not including abortion or abortion counseling
- Pap Smear screening
- Mammography screening
- Colonoscopy screening
- Home health services
- Hospitalization
- Lab and x-ray
- Medical supplies, medical equipment and prosthetic devices in accordance with AHCCCS rules and regulations
- Nursing home care up to 90 days, per contract year
- OB care for pregnant members, including care by a nurse-midwife
- Office visits with PHP provider in accordance with AHCC CS rules and regulations
- Organ transplants in accordance with AHCCCS rules and regulations
- Outpatient hospital services and outpatient health services
- Podiatry care for members age 20 and younger
- Foot and Ankle care for members age 21 and older when performed by a MD, DO, NP or PA
- Preventative health care services for members age 20 and younger
- Limited preventative health care services for members age 21 and older
- Rehabilitation services in accordance with AHCCCS rules and regulations
- Surgery services that have been approved by PHP
- Well Child Care (Early and Periodic Screening, Diagnosis and Treatment - EPSDT) for ages 20 and younger.

SECTION E COVERED SERVICES

DURABLE MEDICAL EQUIPMENT

Covered durable medical equipment (DME) must be medically necessary and prescribed by a PCP or Specialist in accordance with AHCCCS rules and regulations. DME can be obtained by calling the PHP contracted DME Provider. The provider may also call the PHP prior authorization department.

The following limitations shall apply:

- Reasonable repairs or adjustments of purchased medical equipment are covered when necessary to make the equipment serviceable and when the cost of repair is less than the cost of rental or purchase of another unit. The equipment must be considered medically necessary by PHP.
- The rental of such equipment shall terminate no later than the end of the month in which the member no longer needs the medical equipment as certified by the authorized provider or when the member is no longer eligible or enrolled with PHP (except during transitions of care as specified by the health plan's medical director).

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

The early and periodic screening, diagnosis and treatment (EPSDT) program is a program of outreach and medical benefits available to AHCCCS members age 20 and younger. The purpose of the EPSDT program is to provide comprehensive health care through prevention, early intervention, diagnosis and medically necessary treatment to correct or ameliorate defects and physical or mental illness discovered by screening. Additional services covered under EPSDT and in accordance with AHCCCS rules and regulations:

Vision services	Immunizations	Medically Necessary Therapies
Oral Health Services	Behavioral Health Services	Nutritional Assessment & Therapy
Organ & Tissue Transplantation Services	Tuberculosis & Blood Lead Screenings	Religious Non-Medical Health Care Institution Services
Chiropractic Services	Case Management Services	Personal Care Services
Cochlear Implantation	Conscious Sedation	Incontinence Briefs

Please refer to *Section G* of this manual for additional information on EPSDT services.

FAMILY PLANNING SERVICES

Voluntary family planning services are a covered benefit for members who choose to delay or prevent pregnancy. Covered services include medical, surgical, pharmacological and laboratory services, contraceptive devices and information and counseling necessary to allow members to make informed decisions regarding family planning methods.

Please refer to *Section G* of this manual for additional information on family planning services.

FOOT AND ANKLE SERVICES

The following medically necessary foot and ankle services are covered:

Members age 21 and older

SECTION E COVERED SERVICES

- Services provided by a podiatrist or podiatric surgeon are not covered
- Medically necessary routine foot care for members with a severe systemic disease when performed by a MD, DO, NP or PA
- Bunionectomy

Member age 20 and younger

- Medically necessary routine foot care for members with a severe systemic disease, which prohibits care by a nonprofessional person.
- Casting for the purpose of constructing or accommodating medically necessary orthotics
- Medically necessary orthopedic shoes that integrate into a brace
- Bunionectomy

HOME HEALTH

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

All pertinent information must be available and provided at the time of the request. The order for home health care must originate from a physician, either the PCP or designated Specialist on the case.

HOSPICE

PCPs may refer members age 20 years and younger needing hospice care to a contracted hospice provider. Please contact the prior authorization department for additional information and authorization.

HOSPITAL

Covered inpatient services include semi-private accommodations for routine care, intensive and coronary care, surgical care, obstetrics, newborn nurseries and behavioral health emergency/crisis stabilization. If the members' medical condition requires isolation, private inpatient accommodations are covered. All inpatient stays require notification and must be faxed to PHP within twenty-four (24) hours of admission.

HOSPITAL CONCURRENT REVIEW

When a member is admitted to an inpatient facility, a concurrent review nurse (HCRN) conducts admission utilization review on the member as soon as notification and clinical information is received.

On a daily basis, the member's medical record is assessed telephonically, electronically or on-site for medical necessity of the admission and appropriateness of the level of care, utilizing Milliman Care Guidelines

Lower Level of Care Transfers

To promote efficient utilization of services as required by AHCCCS, members will be transferred to the appropriate lower level of care (i.e. Skilled Nursing Facility, Home Health) when medically safe to do so using national standardized criteria.

SECTION E COVERED SERVICES

- Members for whom it is deemed medically appropriate to provide lower level of care will be identified through the health plan's HCRNs and through the utilization review processes.
- When members are identified, the HCRN will discuss the situation with the attending physician, the hospital discharge planning department and the member to identify anticipated needs and services.

PHP will authorize and monitor services provided by the network of contracted providers

LABORATORY SERVICES

Laboratory services for diagnostic, screening and monitoring purposes are covered when referred to a PHP contracted laboratory. Blood draws and/or specimen collections may be completed within the provider's office or the member may be sent to a contracted draw site.

Pre-operative laboratory services should be ordered and completed at a contracted laboratory 24-72 hours prior to the scheduled procedure.

Please refer to *Section F* of this manual, referral procedure and prior authorization process for additional information.

LONG TERM CARE

PHP covers members in a skilled nursing facility up to 90 days pending Arizona Long Term Care Services (ALTCS). Short term stays (less than ninety (90) days in duration) in skilled nursing facilities for the purpose of transitional or step-down care must be prior authorized. On-going care at this level will be monitored on a weekly or as needed basis. The member's medical record is assessed telephonically, electronically or on-site for medical necessity of the appropriateness of the level of care, utilizing Medicare guidelines. Members requiring this type of medical care will be referred to ALTCS for assessment of long term care eligibility and placement at a long-term care facility.

NUTRITION

Nutritional assessment and nutritional supplements, including oral supplements for EPSDT members are covered items when medically necessary. Providers must complete and submit the AHCCCS approved form-“Certificate of Medical Necessity for Commercial Oral Nutritional Supplements” to obtain prior authorization from PHP. If the member meets criteria for medical necessity, the supplement will be covered by PHP. This form can be found in the forms sub-section at the end of this section and on the AHCCCS Medical Policy (Chapter 400) web site:

➤ <http://www.azahcccs.gov/shared/ACOM.aspx?ID=contractormanuals>

Total parental nutrition (TPN) is covered for all members when it is the sole source of nutrition due to severe pathology of the alimentary tract. TPN also may be used to supplement nutrition for EPSDT members when medically necessary.

ORTHOTICS AND PROSTHETICS

Orthotic and prosthetic services are covered when medically indicated and prescribed by a provider in accordance to AHCCCS rules and regulations.

SECTION E COVERED SERVICES

OUTPATIENT REHAB SERVICES

Occupational and Speech Therapy

Members age 21 and older

Occupational and speech therapy are covered for medically necessary inpatient hospital stays.

Children age 20 and younger

Speech therapy and EPSDT Hearing evaluations are covered for members age 20 and younger are covered under the EPSDT and KidsCare programs.

Occupational Therapy is covered for members age 20 and younger under the EPDST and KidsCare programs.

- Children ages 0-3 are to be referred to AzEIP for evaluation and services
- Children may be referred to Children's Rehabilitative Services (CRS) if there is evidence of a CRS covered condition.

Physical Therapy

Members age 21 and older

Physical Therapy is limited to 15 visits during a contracted year for all members on an inpatient or outpatient basis in accordance to AHCCCS rules and regulations.

Children age 20 and younger

- Covered on an inpatient or outpatient basis
- Children ages 0-3 refer to AzEIP for evaluation
- Children may be referred to Children's Rehabilitative Services (CRS) if there is evidence of a CRS covered condition.

PRACTICE GUIDELINES

PHP utilizes practice guidelines for specific areas of medical management and preventive health. These guidelines are approved for use as practice guidelines by the PHP clinical and service quality improvement committee, which include community providers. The guidelines follow standards set by nationally accepted medical organizations.

Guidelines are reviewed annually to determine changes that may need to be made. The review also enables PHP to determine provider participation with the guidelines and participation with the Plan's provider and member education program.

Practice guidelines may be accessed directly on our website at:

➤ http://www.phoenixhealthplan.com/practice_guidelines.aspx

SECTION E COVERED SERVICES

For requests for training, obtaining additional information or receiving a hard copy of these guidelines, please contact network management.

MEDICATIONS AND PHARMACY

PHP uses a generic based formulary. The PHP formulary contains covered drugs listed by therapeutic category and indexed alphabetically. Brand drugs that are available generically will be filled with therapeutically equivalent generic products unless supporting documentation is submitted by the physician and prior authorized by the plan. Some over-the-counter (OTC) pharmacy supplies or drugs are covered and are listed in the formulary. However, a prescription must be written and presented to the pharmacy for coverage of OTC products. Formulary updates are performed on a quarterly basis and are available at:

➤ <http://www.phoenixhealthplan.com/formulary.aspx>

Prescriptions are usually limited to a 30-day supply. This limit is necessary because member eligibility can change monthly.

Some formulary drugs and all non-formulary drugs require prior authorization approval for coverage using the Pharmacy Prior Authorization and Formulary Exception form available on our website or by contacting network management. A completed form along with supporting documentation should be faxed to 602-674-6652 or 1-888-887-9982. *Pharmacy prior authorization requests sent to other fax numbers may result in a delayed review and decision on your request.* Completed pharmacy prior authorization request forms and supporting medical or laboratory documentation should be submitted at the same time. All prior authorization and formulary exception requests will be reviewed to determine if first line formulary drugs have been consistently used for a sufficient length of time. Samples do not constitute an adequate trial. Failures due to a severe adverse drug event must be submitted with supporting documentation (such as CPK, LFT elevations) and may include the FDA MedWatch 3500 form describing the adverse event, outcome and intervention required. For further assistance please call the PHP Pharmacy prior authorization department.

Please refer to *Section K* for additional information.

PRENATAL CARE

PHP believes that all enrolled pregnant women should receive early and adequate prenatal care. PHP, in accordance with State and Federal requirements, has established a maternal child health program (MCH) for pregnant women enrolled with PHP.

Please refer to *Section G* of this manual for additional information.

QUALIFIED MEDICARE BENEFICIARIES

In accordance with federal requirements, PHP members who receive Supplemental Security Income (SSI) and maintain Medicare Part A coverage are entitled to additional AHCCCS benefits as dual eligible Qualified Medicare Beneficiaries (QMB).

The additional Medicare services that the QMB is entitled to include the following:

- Outpatient speech pathology services
- Outpatient occupational therapy

SECTION E COVERED SERVICES

- Psychological services

PHP must be contacted directly for prior authorization and direction of these services to contracted Specialists.

When an assigned PHP member identifies himself/herself as a dual eligible QMB and the provider needs to refer the member for one of the services covered by this program (as listed above), contact member services in order to verify the dual QMB status of the member. Only those services deemed medically necessary by the health plan will be authorized.

RADIOLOGY SERVICES

Radiology services required in the course of diagnosis, prevention and treatment and assessment are covered services. Providers with in-office capability may provide these services or must use a preferred PHP radiology provider.

Mammography

PHP will cover mammography screening for members as recommended by the American Cancer Society. All mammograms should be referred to a preferred radiology provider.

OB Ultrasounds

PHP allows two (2) medically necessary routine OB ultrasounds (2D) under the Total OB Package. Medically necessary 2D ultrasounds beyond the first two (2) and all 3D ultrasounds require prior authorization.

SURGERY SERVICES

All elective and outpatient surgery services must be prior authorized.

Please refer to *Section F*, for additional information on referrals and prior authorizations.

TRANSPLANTS

All transplant procedures require prior authorization. A prior authorization form should be completed and faxed with appropriate medical records to the transplant coordinator.

For members age 20 and younger, covered transplantations include:

- Cornea
- Bone marrow
- Heart
- Lung
- Heart-lung
- Kidney
- Liver

For members age 21 and older, covered transplantation include:

SECTION E COVERED SERVICES

- Cornea
- Bone marrow
- Heart (excluding non-ischemic cardiomyopathies)
- Kidney
- Liver (excluding diagnosis of Hepatitis C)

Transplants must be medically necessary, not experimental, and not for the purpose of research. Members must meet certain criteria to be considered eligible. Any potential transplant candidate must be referred to the transplant coordinator. The transplant coordinator will refer all eligible members to the appropriate provider for a medical evaluation.

AHCCCS covers Ventricular Assist Devices (VADs) as a bridge to heart transplant for eligible members when medically necessary, and when the device is used in accordance with the Food and Drug Administration (FDA) approved labeling instructions.

TRANSPORTATION

PHP provides medically necessary transportation to and from PHP contracted health care providers for members who are not able to arrange or pay for their transportation. PHP members must contact the member services department seventy-two hours in advance of their appointments

Non-Emergency Medical Transportation

- PHP will authorize reimbursement for the level of transport that is necessary for the safe and efficient transfer of members.
- Non-emergent transportation requests must be made through member services with the exception of round trip transports of hospital inpatients for the purpose of diagnostic testing or treatment not available at the hospital. In this situation, the facility will arrange and reimburse all transports directly with the transportation provider.
- If a PHP member or another provider calls a transportation service directly and this contact results in an unauthorized transport, PHP will not be responsible for reimbursement of the service (except as noted above).
- Member services will contact contracted providers to arrange for non-emergent medically necessary transport of members.
- Transportation service providers are to provide timely transportation as specified in their contractual agreement with PHP and according to AHCCCS and PHP policies and procedures.

AHCCCS has standards on timely transportation pick-ups and return home trips. The standard for the initial pick-up allows the member to arrive no more than one hour early to their scheduled appointment. Their return home trip should not allow the member to wait more than one hour at the provider's office from the time of the call requesting them to be pick-up after their appointment for their return home trip.

Emergency Medical Transportation

For any situation deemed to be a medical emergency, call 911. All emergency transportation claims will be retrospectively reviewed for medical necessity.

SECTION E COVERED SERVICES

VISION

Children age 20 and younger

Eye exams and prescriptive lenses and frames for children are covered as follows:

- One exam per year
- One pair of prescriptive lenses per year
- One repair of prescriptive lenses per year

Additional exams and prescriptive lenses are permitted when deemed medically necessary by the health plan Medical Director.

Adults age 21 and older

Emergency eye care which meets the definition of an emergency medical condition is covered for all members.

- Treatment of medical conditions of the eye is covered
- Cataract removal is covered only when there is a reasonable expectation that the member will achieve improved visual functional ability when vision rehabilitation is complete
- Eye exams and lenses are covered if it is the sole prosthetic device after cataract extraction
- Prior authorization is required
- Routine eye exams for prescriptive lenses and the provision of lenses are not covered

Adult members may be referred to the Sight Conservation program through the Arizona Department of Economic Security (DES). The Sight Conservation program provides eye examinations, glasses and other services for the prevention or correction of eye problems to individuals 21 or more years of age that are receiving TANF, GA or SSI, and/or are AHCCCS eligible.

SECTION E COVERED SERVICES

NON-COVERED SERVICES

The services listed below are not covered:

- Services or items furnished solely for cosmetic purposes
- Services or items requiring prior authorization for which prior authorization has not been obtained
- Services not rendered in accordance with AHCCCS rules or contractual requirements
- Services or items furnished gratuitously or for which charges are not usually made
- Services provided in an institution for the treatment of tuberculosis or an institution for the treatment of chronic mental disorders
- Hearing aids, eye examination for prescriptive lenses and prescriptive lenses for eligible persons 21 years of age or older. Glasses or contact lenses are not excluded if they are the sole prosthetic device after a cataract extraction
- Treatment of the basic conditions of alcoholism and drug addiction for adults
- Services determined by the PHP medical director to be experimental or provided primarily for the purpose of research
- Long Term Care services except for AHCCCS covered services provided in state licensed nursing care institutions
- Services of private or special duty nurses other than when medically necessary in a hospital and prior authorized
- Sex change operations and reversal of voluntarily induced infertility (sterilization). Treatment of infertility whether caused by a voluntary procedure or due to disease or reproductive organs
- Care not deemed medically necessary by the PHP medical director, the responsible contractor, or the responsible PCP and not specifically provided for in these regulations
- Medical services provided to a member or eligible person who is an inmate of a public institution or who is in the custody of a state mental health facility
- Outpatient speech and occupational therapy for eligible persons 21 years of age and older
- Physical therapy prescribed only as a maintenance regimen. For members ages 21 and older, visits in excess of 15 visits per contract year are not covered
- Artificial or mechanical hearts and xenografts
- Abortions and hysterectomies that are not medically necessary
- Abortion counseling
- Personal comfort items
- Organ or tissue transplantations that are experimental or are not medically necessary or are not required by state or federal law

SECTION E COVERED SERVICES

- Routine circumcisions that are not medically necessary
- Well exams for members age 21 years and older
- Coverage of new and replacement insulin pumps for members age 21 years and older
- Coverage of new and replacement percussive vests for members age 21 years and older
- Coverage of new and replacement bone-anchored hearing aids for members age 21 years and older
- Coverage of new and replacement cochlear implants for members age 21 years and older
- Emergency dental care for members age 21 years and older
- Microprocessor controlled lower limbs and microprocessor controlled joints for lower limbs
- Podiatry/Podiatric Surgeon visits and services for members age 21 years and older
- Coverage for most orthotics for members age 21 years and older

EXHIBIT 430-3

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CERTIFICATE OF MEDICAL NECESSITY
FOR COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS
(EPSDT MEMBERS)**

SUBMITTED BY:

Provider Name: _____

Provider AHCCCS ID Number: _____ Telephone: _____

MEMBER INFORMATION

Member's Name: _____ Date of Birth: _____
Last First Initial

Member's AHCCCS ID Number: _____ Enrollment: _____
(Contractor)

Member's Address: _____

ASSESSMENT FOR COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS

Assessment performed by: _____

AHCCCS Provider ID: _____ Telephone Number: _____

Date of Assessment: _____

Assessment Findings: (If necessary, add attachments to provide the most complete information)

1. Indicate which of the following criteria have been met to determine that oral supplemental nutritional feedings are medically necessary. (At least two of the following must be met.) Check all that apply.

a. The member is at or below the 10th percentile on the appropriate growth chart for their age and gender for 3 months or more.	
b. The member has reached a plateau in growth and/or nutritional status for more than 6 months (prepubescent).	
c. The member has already demonstrated a medically significant decline in weight within the past 3 months (prior to the assessment).	
d. The member is able to consume/eat no more than 25% of his/her nutritional requirements from normal food sources.	
e. Absorption problems are evidenced by emesis, diarrhea, dehydration, weight loss, and intolerance to milk or formula products has been ruled out.	
f. The member requires oral supplemental nutritional feedings on a temporary basis due to an emergent condition; i.e. post-hospitalization. (No PA for first 30 days)	
g. The member is at risk for regression due to chronic disease or condition.	

EXHIBIT 430-3

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CERTIFICATE OF MEDICAL NECESSITY
FOR COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS
(EPSDT MEMBERS)**

2. List past nutritional counseling efforts and alternative nutritional feedings which were tried (include by whom and the length of time that counseling was conducted and/or the alternative feedings that were used.)

ORAL SUPPLEMENTAL NUTRITIONAL FEEDING RECOMMENDATIONS

Type of Nutritional Feeding	Source of Nutrition
Weaning from Tube Feeding	
Oral Feeding - Sole Source (PA required)	
Oral Feeding - Supplemental (PA Required)	
Emergency Supplemental Nutrition (No PA required for first 30 days)	

Additional Comments:

Nutritional Assessment Provider Date

Member's PCP/Attending Physician Date

Revised: 4/1/2007
Effective: 1/1/2000