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MATERNAL AND CHILD HEALTH (MCH)

Phoenix Health Plan (PHP) is dedicated to providing quality health care to pregnant women and children age 20 and younger. PHP needs the assistance of providers to deliver quality care and improve outcomes of these members. Within the medical services quality department, PHP has a MCH unit which assists providers with coordinating care for obstetrical and pediatric members. The MCH unit is responsible for overseeing the following AHCCCS mandated programs:

- EPSDT (including immunizations and dental outreach)
- Family Planning Services
- Maternity Care

Refer to AHCCCS Medical Policy Manual (AMPM) Chapter 400 for additional details regarding covered services for Maternity Care, Family Planning Services, and EPSDT.

FAMILY PLANNING SERVICES

Providers are expected to discuss the availability of family planning with members of childbearing age at well visits/annual visits.

Voluntary family planning services are a covered benefit for PHP members who choose to delay or prevent pregnancy. Covered services include medical, surgical, pharmacological and laboratory services, contraceptive devices, as well as information and counseling necessary to allow members to make informed decisions regarding family planning methods. No authorization is required for family planning services; however, the diagnosis must indicate family planning.

Covered services include, but are not limited to, the following for male and female members:

- Condoms
- Depo-Provera
- Diaphragms
- Emergency Oral Contraception
- Foams, jellies, suppositories
- Intrauterine devices (IUDs)
- Natural family planning
- Oral contraceptives
- Sterilization (bilateral tubal ligation and vasectomy require prior authorization)

Non-covered services for the purpose of family planning include:

- Pregnancy termination counseling
- Pregnancy terminations and hysterectomies
- Infertility services including diagnostic testing, treatment, or reversal of surgically induced infertility

Prior authorization is not required for family planning services with the exceptions of tubal ligations and vasectomies. AHCCCS requires a completed federal consent form for all voluntary sterilization
procedures and the form must accompany the request for authorization for the sterilization. The Consent for Sterilization form can be found at:


The member must be at least twenty-one (21) years of age and mentally competent to sign the consent form and the form must be signed at least thirty days, but no more than one hundred eighty (180) days, prior to the sterilization procedure.

In conjunction with the federal informed consent form, a member must be offered factual information including the following:

- Consent form requirements
- Answers to questions asked by the member regarding the specific procedure to be performed
- Notification that the consent can be withdrawn at any time prior to the surgery without affecting future care and/or loss of federally funded benefits
- A description of available alternative methods
- A full description of the risks and discomforts that may accompany or follow the performing of the procedure, including an explanation of the type and possible side effects of anesthetic to be used
- A full description of the benefits or disadvantages that may be expected as a result of the sterilization
- Notification that sterilization cannot be performed for at least 30 days post consent.

Sterilization consent **CANNOT** be obtained when an eligible person is:

- In labor or childbirth
- Seeking to obtain or is obtaining an pregnancy termination
- Under the influence of alcohol or other substances that affect the eligible person's state of awareness

PCPs are expected to verbally notify PHP members of reproductive age of the availability of family planning services on an annual basis during an office visit, and to provide the requested family planning method as appropriate to the member. No co-payment may be collected for family planning services.

**MEDICALLY NECESSARY PREGNANCY TERMINATIONS**

Pregnancy terminations are a covered service only if determined to be medically necessary and one of the following conditions is met:

- The member suffers from a physical disorder, injury, or illness including a life endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the member in danger of death unless the pregnancy is terminated.
- The pregnancy is a result of rape or incest. Documentation must be obtained that the incident was reported to the authorities, including the name of the agency to which it was reported, the report number if available and the date the report was filed.
- 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:
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- Creating a serious physical or mental health problem for the pregnant member
- Seriously impairing a bodily function of the pregnant member
- Causing dysfunction of a bodily organ or part of the pregnant member
- Exacerbating a health problem of the pregnant member, or
- Preventing the pregnant member from obtaining treatment for a health problem.

A written informed consent must be obtained by the provider and kept in the member's chart for all pregnancy terminations. If the pregnant member is age 18 and younger, or is age 18 and older and considered an incapacitated adult, a dated signature of the pregnant member's parent or legal guardian indicating approval of the pregnancy termination procedure is required.

Prior authorization is required for medically necessary pregnancy terminations. A Completed Certificate of Medical Necessity for Pregnancy Termination form must be submitted with the authorization request and certification of the condition, disorder, illness or injury, along with the lab, radiology, consultation or other testing results that support the justification/necessity for pregnancy termination. This includes a copy of an official incident report in cases of rape or incest.

For additional information or assistance in determining if a situation meets the above criteria, please contact the MCH unit.

MATERNITY CARE

Initial Pre-Natal Appointments

AHCCCS mandates specific standards for appointment availability for initial pre-natal care, as follows:

- First trimester: Within 14 days of request
- Second trimester: Within 7 days of request
- Third trimester: Within 3 days of request
- High risk pregnancies: Within 3 days of identification of high risk or immediately if an emergency exists

Obstetrical Provider Responsibilities

Providers are expected to follow the standards listed below:

- Adhere to the standards of care of the American Congress of Obstetricians and Gynecologists (ACOG), including the use of a standardized medical risk assessment tool (ACOG or MICA), and ongoing risk assessment
- Maintain complete medical records documenting all aspects of maternity care
- Educate and document the education of members about healthy behaviors during pregnancy including proper nutrition, tobacco cessation, dangers of lead exposure to mother and child; avoidance of alcohol and other harmful substances, including illegal drugs, screening for sexually transmitted infections, the physiology of pregnancy including the process of labor and delivery, breastfeeding and other infant care information, and postpartum follow-up
- Counsel and offer voluntary HIV testing to women as early as possible during pregnancy, documenting when HIV counseling is conducted and whether HIV testing was obtained or refused.
- Conduct perinatal/postpartum depression screenings at least once during the pregnancy and then repeated at the postpartum visit with appropriate counseling and referrals made, if a positive
screening is obtained. (Note: postpartum depression screening is considered part of the global service and is not a separately reimbursable service.)

- Refer members to community resources such as Women, Infants and Children (WIC) and other community-based resources to support healthy pregnancy outcomes
- Record the first and last prenatal care dates of service, as well as the number of obstetrical visits that the member had with the provider, on all claim forms submitted regardless of the payment methodology used.
- Provide postpartum services to members within 60 days of delivery utilizing a separate “zero-dollar” claim for the postpartum visit.
- Notify PHP's MCH unit of members who are non-compliant with prenatal care appointments, or of other situations which place the member at risk for a poor birth outcome
- Notify members that in the event they lose eligibility for services, they may contact the Arizona Department of Health Services Hotline for referrals to low-cost or no-cost services

**Return Pre-Natal Appointments**

Prenatal visits should be schedule routinely after the initial visit, as follows:

- Every four (4) weeks for the first twenty-eight (28) weeks
- Every two-three (2-3) weeks until thirty-six (36) weeks
- Weekly from thirty-seven (37) weeks until delivery
- High-risk patients will have return visits scheduled as appropriate for their individual needs

**Reporting Missed Appointments**

Providers must use an appointment system that identifies missed appointments. When making an initial appointment, please verify the member's current name, address and telephone number. Also, obtain the name and phone number of a person outside the member's household to serve as an alternate contact.

Please contact the MCH unit with the name of any pregnant member who misses a prenatal appointment. The MCH unit has outreach programs available to pregnant members.

*Note:* All PHP members who are pregnant and age 20 and younger are expected to receive an EPSDT screening at the initial prenatal appointment. Please refer to EPSDT guidelines later in this section.

**Loss of Eligibility**

Members may lose eligibility for AHCCCS coverage during pregnancy. Although members are responsible for their own eligibility, providers are encouraged to notify PHP if they are aware that a pregnant member is about to lose or has lost eligibility.

**Obstetrical Provider Audits**

All obstetrical providers are audited periodically. The audit tool measures compliance with appointment standards and provider responsibilities.

**High Risk Pregnancies**

PHP will identify pregnant women who are "at risk" for adverse pregnancy outcomes. Providers are
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responsible for identifying risk factors associated with pregnancy by using either the ACOG or MICA risk assessment tools. Both are comprehensive assessment tools that cover psychosocial, nutritional, and medical and education factors. PHP also considers factors such as non-compliance with prenatal care appointments and medical treatment plans in determining risk status. Please send completed ACOG forms to PHP within 2 weeks of the first visit.

Consultation with a contracted perinatologist is strongly encouraged based on the professional judgment of the provider.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a comprehensive child health program of prevention, treatment, correction, and improvement (amelioration) of physical and behavioral/mental health conditions for AHCCCS members under 21 years of age. The purpose of EPSDT is to ensure the availability and accessibility of health care resources, as well as to assist PHP members in effectively utilizing these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health conditions. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary, mandatory, and optional services listed in Federal Law 42 USC 1396d (a) to correct or ameliorate defects and physical and behavioral/mental illnesses and conditions identified in an EPSDT screening, whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services. A well child visit is synonymous with an EPSDT visit.

EPSDT Definitions

- **Early** means, in the case of a child already enrolled with an AHCCCS Contractor, as early as possible in the child's life, or in other cases, as soon after the member's eligibility for AHCCCS services has been established.
- **Periodic** means at intervals established by AHCCCS for screening to assure that a condition, illness, or injury is not incipient or present.
- **Screening** means regularly scheduled examinations and evaluations of the general physical and behavioral health, growth, development, and nutritional status of infants, children and adolescents, and the identification of those in need of more definitive evaluation. For the purpose of the AHCCCS EPSDT program, screening and diagnosis are not synonymous.
- **Diagnostic** means the determination of the nature or cause of a condition, illness, or injury through the combined use of health history, physical, developmental and psychological examination, laboratory tests, and X-rays, when appropriate.
- **Treatment** means any of the 29 mandatory or optional services described in Federal Law 42 USC 1396d (a), even if the service is not covered under the (AHCCCS) State Plan, when necessary to correct or ameliorate defects and physical and mental illnesses and conditions detected by screening or diagnostic procedures.

EPSDT Screening

EPSDT screening services are provided in compliance with the periodicity requirements of Title 42 of the Code of Federal Regulations (42 C.F.R. 441.58). Contractors must ensure members receive required
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health screenings in compliance with the AHCCCCS EPSDT Periodicity Schedule and the AHCCCS Dental Periodicity Schedule.

Screening requirements are the core of EPSDT and must include the following (see detailed descriptions below):

- A comprehensive health and developmental history, including growth and development screening which includes physical, nutritional and behavioral health assessments
- Nutritional Assessment
- Behavioral Health Screening and Services
- Developmental Screening Tools for EPSDT members from birth through three years of age during the 9 month, 18 month and 24 month EPSDT visits
- Comprehensive unclothed physical exam
- Appropriate immunizations according to age and health history
- Laboratory tests including blood lead screening assessment and blood lead testing appropriate to age and risk
- Health education, counseling, and chronic disease self-management
- Oral health screening, intended to identify oral pathology, including tooth decay and/or oral lesions, and the application of fluoride varnish conducted by a physician, physician’s assistant or nurse practitioner
- Vision, hearing, and speech screenings
- Tuberculin skin testing

PCPs (including OB/GYNs selected as PCPs) must provide a complete, age-appropriate screening as defined on the AHCCCS periodicity schedule found in Chapter 400, Exhibit 430-1 of the at:


The periodicity schedule is intended to meet reasonable standards of medical and dental practice and specifies screening services at each stage of the child's life. EPSDT providers are sent a monthly listing of their assigned members who are due for an EPSDT screening exam during that month. PHP encourages all providers to utilize this list as a worksheet to identify and contact members who do not make an EPSDT appointment during that month. All PCPs must review the member's medical record and complete an age appropriate EPSDT Tracking Form at each well child visit and provide any appropriate EPSDT services at that time.

Claims for EPSDT services must be submitted on a CMS (formerly HCFA) 1500 form. Providers must bill for preventative EPSDT services using the preventative service, office or other outpatient services and preventive medicine CPT codes (99381 – 99385, 99391 – 99395) with an EP modifier. EPSDT visits are paid at a global rate for the services specified in the AMPM. With the exception of items listed as separately reimbursable services, no additional reimbursement is allowed. Providers must use an EP modifier to designate all services related to the EPSDT well child check-ups, including routine vision and hearing screenings.

**Comprehensive Health and Developmental History**

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/](http://www.cdc.gov/growthcharts/) for Body Mass Index (BMI) and growth chart resources.)
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The complete history must be obtained from the parent or responsible adult familiar with the health history. Developmental Surveillance shall be accomplished at all EPSDT visits as indicated on the EPSDT Tracking Forms. A full assessment should be done if potential developmental delays or concerns are identified.

Nutritional Assessment Provided by a PCP

Nutritional assessments are conducted to assist EPSDT members whose health status may improve with nutritional intervention. Payment for the assessment of nutritional status provided by the member's PCP is part of the EPSDT screening, as specified in the AHCCCS EPSDT Periodicity Schedule and on an inter-periodic basis as determined necessary by the member’s PCP.

Behavioral Health Screening and Services Provided by a PCP

PHP covers behavioral health services for members eligible for EPSDT. EPSDT behavioral health services include the services listed in Federal Law 42 USC 1396d(a) necessary to correct or ameliorate mental illnesses and conditions discovered by the screening services, whether or not the services are covered under the (AHCCCS) State Plan. PCPs may treat Attention Deficit Hyperactivity Disorder (ADHD), depression and anxiety. All other behavioral health conditions must be referred to the Regional Behavioral Health Authority (RBHA). American Indian members may receive behavioral health services through an Indian Health Service or Tribally operated 638 facility, with the exclusion of ALTCS, Maricopa Integrated RBHA and CRS programs. PCPs that elect to prescribe medications to treat ADHD, depression, or anxiety disorders must complete an annual assessment of the member’s behavioral health condition and treatment plan. Payment for behavioral health screenings and assessments are included as part of an EPSDT visit and are not separately billable services.

NOTE: CPT code 96101 - PSYCHOLOGICAL TESTING (includes psychodiagnostic 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.

Screening for mental health and substance abuse problems must be conducted at each comprehensive EPSDT visit. A behavioral health screening consists of an interview with the child and his/her parent(s) or accompanying adult and an observation of the child and his/her interactions with parent(s), office staff, and provider. Questions assess the child's relationship to self and others. The pediatric symptom checklist (ages 6 to 12) or other pediatric behavioral health screening tools may be used at the discretion of the PCP. A copy of the PHP behavioral health program description can be obtained by calling the PHP Behavioral Health Coordinator.

Screening for behavioral health referrals should include questions which cover broad areas of the child's age appropriate functioning. The following are examples:

- How is the child doing at home?
- How does the child interact with mother? With father? Does the child respond to parent requests as expected?
- Does the child get along with siblings? Are there indications of aggressive behavior towards younger children? Are other children aggressive towards this child?
- If extended family members are present in the home, how does the child get along with them? Are there problems in how they interact with the child or the child with them?
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- Does the child's parent have any concerns about the child's behavior with family members?
- Does the child express any concern about his/her relationships at home?
- How does the child do in school (kindergarten, preschool, daycare, etc.)?
- Does the child have academic problems?
- Does the child get along satisfactorily with teachers?
- Do teachers report the child has difficulty behaving as expected at school? If yes, does the parent agree this is a problem? Does the child? Does the child interact with other children in age appropriate ways?
- Has the child ever been seen by the school psychologist or counselor? For what reasons? Is the issue resolved to the satisfaction of the counselor, parent and child?
- Does the child use alcohol or drugs?
- Does the parent(s) have any concerns about the child and his/her behavior or activities?

If the PCP thinks behavioral health services may be appropriate based on responses to the screening questions, a referral to the RBHA should be made.

The following are some key areas of concern:

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Mood</th>
<th>Thinking</th>
<th>Neurovegetative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggressive</td>
<td>Depressed</td>
<td>Confused</td>
<td>Enuresis</td>
</tr>
<tr>
<td>Self-destructive</td>
<td>Anxious</td>
<td>Disoriented</td>
<td>Encopresis</td>
</tr>
<tr>
<td>Withdrawn</td>
<td>Irritable</td>
<td>Disorganized</td>
<td>Energy</td>
</tr>
<tr>
<td>Attention problems</td>
<td>Euphoria</td>
<td>Memory problems</td>
<td>Pain</td>
</tr>
<tr>
<td>Overactive</td>
<td>Apathy</td>
<td>Learning problems</td>
<td>Eating</td>
</tr>
<tr>
<td>Defiant</td>
<td>Sleepy</td>
<td>Delusional</td>
<td></td>
</tr>
<tr>
<td>Drug abuse</td>
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<td></td>
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<tr>
<td>Sexually inappropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medically non-compliant</td>
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</tr>
</tbody>
</table>

Also, an indication of acuity and severity of problems should be indicated:

<table>
<thead>
<tr>
<th>Type of Problem</th>
<th>Severity of Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute problem</td>
<td>Mild</td>
</tr>
<tr>
<td>Recurrent problem</td>
<td>Moderate</td>
</tr>
<tr>
<td>Multiple problems</td>
<td>Marked</td>
</tr>
<tr>
<td>Long-term problem</td>
<td>Extreme</td>
</tr>
</tbody>
</table>

Developmental Screening Tools used by a PCP

AHCCCS approved developmental screening tools should be utilized for developmental screening by all participating PCPs who care for EPSDT-age members. PCPs must be trained in the use and scoring of the developmental screening tools, as indicated by the American Academy of Pediatrics (A list of available training resources may be found in the Arizona Department of Health Services website at www.azdhs.gov/clinicians/training-opportunities/developmental/index.php).

All qualified medical professionals must provide proof of certification to the Council for Affordable Quality Healthcare (CAQH). The CAQH fax cover sheet should be used to send the required documentation of your completed training to CAQH. Please use the code 014, Formal Post-Graduate
Training Certificates, when providing your documentation. PHP will use the CAQH data base to conduct random audits to ensure provider compliance with the AHCCCS training requirement. Certificates dated before August 1, 2014 will be accepted.

The developmental screening should be completed for EPSDT members from birth through three years of age during the 9 month, 18 month and 24 month EPSDT visits. A copy of the screening tool must be kept in the medical record.

Use of AHCCCS approved developmental screening tools may be billed separately using CPT-4 code 96110 (Developmental screening, with interpretation and report, per standardized instrumentation) for the 9 month, 18 month and 24 month visit when the developmental screening tool is used. A developmental screening CPT code (with EP modifier) must be listed in addition to the preventive medicine CPT codes. Other CPT-4 codes, such as 96111 – Developmental Testing (includes assessment of motor, language, social, adaptive) are not considered screening tools and are not separately billable. To receive the developmental screening tool payment, the modifier EP must be added to the 96110. For claims to be eligible for payment of code 96110; the provider must have satisfied the training requirements, the claim must be a 9, 18, or 24-month EPSDT visit, and an AHCCCS approved developmental screening tool must have been completed.

AHCCCS approved developmental screening tools include:

a. The Parent’s Evaluation of Developmental Status (PEDS) tool which may be obtained from www.pedstest.com or www.forepath.org

b. Ages and Stages Questionnaire (ASQ) tool which may be obtained from www.agesandstages.com

c. The Modified Checklist for Autism in Toddlers (MCHAT) which may be used only as a screening tool by a primary care provider, for members 16-30 months of age, to screen for autism when medically indicated. Copies of the completed tools must be retained in the medical record

**Immunizations**

EPSDT covers all child and adolescent immunizations, as specified in the Centers for Disease Control and Prevention (CDC) recommended childhood immunization schedules. All appropriate immunizations must be provided to establish, and maintain, up-to-date immunization status for each EPSDT age member. (Refer to the CDC website at http://www.cdc.gov/vaccines/schedules/index.html for current immunization schedules.)

Immunization status of the child must be assessed at each visit, including both acute and preventive visits. A current immunization record must be in the medical chart. When a child's immunization status is not up to date, appropriate immunization(s) must be provided. Please refer to chapter 400 of the AHCCCS medical policy manual for additional information at:


PCPs must document each EPSDT age member’s immunizations in the Arizona State Immunization Information System (ASIIS) registry. In addition, PCPs must maintain the ASIIS immunization records of each EPSDT member in ASIIS, in accordance with A.R.S. Title 36, Section 135. PHP is required to monitor PCP compliance with immunization registry reporting requirements and take action to improve reporting when issues are identified.
Appropriate immunizations according to age and health history (administration of the immunizations may be billed in addition to the EPSDT visit using the CPT-4 code appropriate for the immunization with an SL modifier). Combination vaccines are paid as one vaccine.

PCPs 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 at http://www.cdc.gov/vaccines/schedules/index.html where this information is included). PCPs with members under age 19 assigned to panel must be registered as VFC providers and VFC vaccines must be used. Failure to enroll/reenroll with VFC will result in reassignment of members 0-18 years of age to other providers. The Vaccines for Children (VFC) Program is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. The program was officially implemented in October 1994 as part of the President's Childhood Immunization Initiative. Funding for the VFC Program allows the Centers for Disease Control and Prevention (CDC) to buy vaccines at a discount from the manufacturers and distribute them to state health departments and certain local and territorial public health agencies, which in turn distribute them at no charge to private physician offices and public health clinics registered as VFC providers. Children birth through 18 years of age, who meet at least one of the following criteria on the day the vaccine is administered, are eligible to receive VFC vaccine:

- Medicaid eligible: In Arizona, children whose health insurance is covered by the Arizona Health Care Cost Containment System (AHCCCS)
- Un-insured: A child who has no health insurance coverage
- American Indian or Alaska Native: As defined by the Indian Health Services Act
- Under-insured*:
  - A child who has commercial (private) health insurance but the coverage does not include vaccines,
  - A child whose insurance covers only selected vaccines (VFC-eligible for non-covered vaccines only),
  - A child whose insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured and is eligible to receive VFC vaccines.

As of July 1, 2013, Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC), County Health Departments and approved deputized providers are allowed to serve the VFC eligibility category of Underinsured. All other providers will only be allowed to serve the VFC eligibility categories of Medicaid, Un-insured, and American Indian/Alaskan Native. There are also no changes to provider’s ability to serve KidsCare children.

For further information, please contact the VFC Program at the ADHS Arizona Immunization Program Office at 602-364-3642. ARS § 36-135 requires all immunizations administered to a child under age 19 be reported to ASIIS, the state registry program, regardless of whether the vaccine is VFC or privately purchased.

PHP will cover the Human Papilloma Virus (HPV) vaccine for female and male EPSDT members age 11 through 20 years. Additionally, members nine and ten years of age are covered, if the member is deemed to be in a high-risk situation.
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Contractors must ensure providers enroll and re-enroll annually with the VFC program, in accordance with AHCCCS Contract requirements. The Contractor shall not utilize AHCCCS funding to purchase vaccines covered through the VFC program for members younger than 19 years of age.

Lab Testing

Laboratory tests including blood lead screening assessment and blood lead testing appropriate to age and risk, anemia testing and diagnostic testing for sickle cell trait (if a child has not been previously tested with sickle cell preparation or a hemoglobin solubility test).

EPSDT covers blood lead screening. Required blood lead screening for children under six year of age is based on the child’s risk as determined by either the member’s residential zip code or presence of other known risk-factors, as specified in the ADHS Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning.

a. Children living in a targeted high-risk zip code: All children living in a high risk zip code as identified by the ADHS Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning must have a blood lead test at 12 and 24 months of age. Children between 36 and 72 months of age must receive a screening blood lead test, if they have not been previously screened for lead poisoning.

b. Children living outside of the targeted high-risk zip codes: Children living in Arizona, but not in a targeted high-risk zip code must receive an individual risk assessment (questionnaire below) according to the AHCCCS periodicity schedule (when the child is 6, 9, 12, 18, and 24 months of age and then annually through age 6 years), with appropriate follow-up action taken for those children who are determined to be at high risk based on criteria included within the ADHS Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning.

The provider must discuss with the child's parent or guardian childhood lead poisoning interventions and assess the child's risk for exposure. The following questions should be asked:

IN THE PAST YEAR HAS YOUR CHILD . . .
LIVED IN OR REGULARLY VISITED:

YES / NO  A house built before 1978 that has been remodeled within the past 6 months or has peeling, chipping, or flaking paint

YES / NO  A sibling, cousin, or friend that has been diagnosed or treated for lead poisoning

YES / NO  Near a factory or industrial plant

YES / NO  Mexico, India, Middle East, Central America, South America, Africa, or Asia

BEEN AROUND ADULTS WHO:

YES / NO  Hunt, fish, reload bullets, refinish furniture, stain glass, work with metal, or paint with fine artist paints

YES / NO  Work as plumbers, mechanics, constructions workers, miners, or welders

EATEN OR DRUNK:

YES / NO  From ceramic cookware/dishware or imported pottery
A blood lead test result, equal to or greater than 10 micrograms of lead per deciliter of whole blood obtained by capillary specimen or fingerstick, must be confirmed using a venous blood sample. A verbal blood lead screening risk assessment must be completed at each EPSDT visit for children six through 72 months of age (six years of age) to assist in determining risk.

Providers must report blood lead levels equal to or greater than ten micrograms of lead per deciliter of whole blood to ADHS (A.A.C. R9-4-302).

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 provider’s contract with PHP.

Health Education, Counseling, and Chronic Disease Self-Management

The PCP is responsible for ensuring that health education, counseling and chronic disease self-management are provided at each EPSDT visit. Anticipatory guidance should be provided regarding development, benefits of a healthy lifestyle, and accident and disease prevention, including obesity prevention, diagnosis, and treatment.

Health education, counseling, and chronic disease self-management are not separately billable services and are considered part of the EPSDT visit payment.

Oral Health Screening

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. 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.

PCPs must refer EPSDT members for appropriate services based on needs identified through the screening process and for routine dental care starting at age 1 based on the AHCCCS EPSDT Periodicity Schedule. Evidence of this referral must be documented on the EPSDT Tracking Form and in the member’s medical record.

PCPs who have completed the AHCCCS required training, may be reimbursed for fluoride varnish applications (CPT Code 99188) completed at the EPSDT visits for members who are at least six months of age, with at least one tooth eruption. Additional applications occurring every six months during an EPSDT visit, up until member’s second birthday, may be reimbursed according to AHCCCS-approved fee schedules. Application of fluoride varnish by the PCP, does not take the place of an oral health visit.

In order to receive payment for the application of fluoride varnish, PCPs must be certified in the application process. The AHCCCS recommended training is located at:
Training Opportunities - Developmental Screening & Fluoride Varnish Training

All qualified medical professionals must provide proof of certification to the Council for Affordable Quality Healthcare (CAQH). The CAQH fax cover sheet should be used to send the required documentation of your completed training to CAQH. Please use the code 014, Formal Post-Graduate Training Certificates, when providing your documentation. PHP will use the CAQH data base to conduct random audits to ensure provider compliance with the AHCCCS training requirement. Certificates dated before August 1, 2014 will be accepted.

Vision, Hearing, and Speech Screenings

Appropriate vision, hearing, and speech screenings are covered during an EPSDT visit. EPSDT covers eye examinations as appropriate to age according to the AHCCCS EPSDT Periodicity Schedule (Exhibit 430-1) and as medically necessary using standardized visual tools. Payment for vision and hearing exams, (including, but not limited to CPT codes 92015, 92081, 92285, 92551, 92552, 92553, 92567, 92568, 92285, 92286, 92587, 92588, 95930, and 99173) or any other procedure that may be interpreted as fulfilling the vision and hearing requirements provided in a PCP’s office during an EPSDT visit, are considered part of the EPSDT visit and are not a separately billable services.

Ocular photoscreening with interpretation and report, bilateral (CPT code 99174) is covered for children ages three to five as part of the EPSDT visit due to challenges with a child’s ability to cooperate with traditional vision screening techniques. Ocular photoscreening is limited to a lifetime coverage limit of one.

Prescriptive lenses and frames are provided to correct or ameliorate defects, physical illness and conditions discovered by EPSDT screenings, subject to medical necessity. Frames for eyeglasses are also covered.

Vision CPT codes with the EP modifier must be listed on the claim form in addition to the preventive medicine CPT codes for visit screening assessment. With the exception of CPT code 99174, no additional reimbursement is allowed for these codes.

Hearing CPT codes with the EP modifier must be listed on the claim form, in addition to the preventive medicine CPT codes, for a periodic hearing screening assessment. With the exception of CPT code 99174, no additional reimbursement is allowed for these codes.

Tuberculin Skin Testing as Appropriate to Age and Risk

Children at increased risk of Tuberculosis (TB) include those who have contact with persons:

a. Confirmed or suspected as having TB,
b. In jail or prison during the last five years,
c. Living in a household with an HIV-infected person or the child is infected with HIV, and
d. Traveling/emigrating from, or having significant contact with persons indigenous to, endemic countries.

Coordination with Other Agencies
Coordination with WIC, Head Start, and other private and public resources enables elimination of duplicate testing, and ensures comprehensive diagnosis and treatment. Also, public health agencies' childhood lead poisoning prevention programs may be available. These agencies may have the authority and ability to investigate a lead-poisoned child's environment and to require remediation. Should further assistance be required with a pediatric member diagnosed with an elevated lead level, please contact PHP's MCH Coordinator.

Nutritional Assessment and Nutritional Therapy

The Arizona Women, Infants, and Children (WIC) Program serves eligible pregnant, breastfeeding and postpartum women, infants, and children up to 5 years of age. According to AHCCCS policy 400 Section 430.C.6, Nutritional Assessment and Nutritional Therapy, “If an AHCCCS covered [EPSDT] member qualifies for nutritional therapy due to a medical condition, then AHCCCS Contractors are the primary payor for WIC-eligible exempt infant formulas and medical foods, [including commercial oral nutritional supplements]”.

Prior authorization is required for commercial oral nutritional supplements unless the member is also currently receiving nutrition through enteral or parenteral feedings. Providers must complete and submit the AHCCCS approved form, “Certificate of Medical Necessity for Commercial Oral Nutritional Supplements” (Exhibit 430-2), to obtain prior authorization from PHP. If the member meets criteria for medical necessity, the supplement will be covered by PHP.

For more information related to nutritional assessments and nutritional therapy, refer to the AHCCCS Medical Policy Manual (Chapter 400) web site:


For more information related to WIC, including WIC office locations and contact information can be found online at www.azwic.gov.

EPSDT Mass Mailings

On a monthly basis, PHP mails to each provider a list of assigned members who are due for an EPSDT visit that month. A mailing is also sent to members as a reminder. Providers are encouraged to utilize the list to ensure members are getting in for their EPSDT visits on a timely basis.

ARIZONA EARLY INTERVENTION PROGRAM (AzEIP)

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

PCP Initiated Service Requests

When concerns about a child’s development are initially identified by the PCP, the PCP will request an evaluation and, if medically necessary, approval of services from PHP.

1. Screening/Identification: During the EPSDT visit, the PCP will determine the child’s developmental status through discussion with the parents/caregiver and developmental screening. If the PCP identifies potential developmental delays, the PCP requests an evaluation and possibly service authorization from PHP. The PCP must submit the clinical information to support the request for evaluation and any services. In addition, the PCP must consider related screening and
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evaluation needs when exploring if a child has a developmental delay. For example, 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.

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

a. Requests for services from Primary Care Provider, licensed providers or the AzEIP service coordinator based on the Individual Family Service Plan (IFSP) must be reviewed for medical necessity prior to authorization and reimbursement.

b. If services are approved based on the determination of medical necessity, PHP will authorize the services and notify the PCP (or requesting provider, if other than the PCP) that (a) the services are approved and (b) identify the provider that has been authorized, the frequency, the duration, the service begin and end dates.

c. Referral to AzEIP: After the completion of the evaluation, the provider who conducted the evaluation will submit an Evaluation Report to the PCP (requesting provider if other than the PCP) and the PHP Prior Authorization department for authorization of medically necessary services.

i. If the evaluation indicates that the child scored two standard deviations below the mean, which generally translates to AzEIP’s eligibility criteria of 50 percent developmental delay, the child will continue to receive all medically necessary EPSDT covered services through PHP. PHP will refer the child to AzEIP for non-medically necessary services that are not covered by Medicaid but are covered under IDEA Part C.

ii. If the evaluation report indicates that the child does not have a 50 percent developmental delay, PHP will continue to coordinate medically necessary care and services for the child.

d. PHP and AzEIP will continue to coordinate services for members who are eligible for and enrolled in both PHP and AzEIP. PHP assists the parent/caregiver in scheduling the EPSDT covered services, as necessary or as requested. The EPSDT services will be provided by PHP contracted providers (or AzEIP service providers reimbursed by the AHCCCS Health Plan) until the services are determined by the PCP and provider to no longer be medically necessary.

AzEIP Initiated Service Requests

When concerns about a PHP member’s development are initially identified by AzEIP:

1. If an EPSDT eligible child is referred to AzEIP, AzEIP will screen and, if needed, conduct evaluation to determine the child’s eligibility for AzEIP. AzEIP will obtain parental consent to request and release records to/from PHP and the child’s PCP.

2. If the child is determined to be AzEIP eligible, AzEIP will develop an IFSP that will identify (1) the child’s present level of development, (2) child outcomes, and (3) the services that are needed to support the family and child in reaching the IFSP outcomes, and (4) the planned start date for
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each early intervention service(s) identified on the IFSP. IFSP services that are EPSDT covered will identify PHP as the payer.

3. The AzEIP service coordinator will send (fax or e-mail) the AzEIP AHCCCS Member Service Request form and copies of the evaluations/developmental summaries completed during the IFSP process to the PHP within two business days of completing the IFSP.

4. PHP ensures the service request is entered into the prior authorization system within one business day of receipt of the request.

5. PHP sends (faxes/e-mails) the AzEIP AHCCCS Member Service Request form and accompanying documentation to the member’s PCP within two business days.

6. The PCP will review all AzEIP documentation and determine which services are medically necessary based on review of the documentation.

7. The PCP shall take no longer than ten business days from the date that PHP faxes the documentation to the PCP to determine which services are medically necessary and return the signed AzEIP AHCCCS Member Service Request form to PHP.

8. The PCP will determine:
   a. The requested services are medically necessary:
      i. Within two business days PHP will send the completed AzEIP AHCCCS Member Service Request form to the AzEIP service coordinator and PCP advising them that:
         (a) The services are approved, and
         (b) Identify the provider that has been authorized, the frequency, the duration, the service begin and the service end dates.
   b. The requested services are not medically necessary:
      i. PHP will notify the AzEIP service coordinator within two business days of receipt of the PCP’s determination and that services are denied.
      ii. PHP will send a Notice of Action (NOA) to the PCP, the member’s guardian/parent and the AzEIP service coordinator notifying them that the service is denied.
      iii. The AzEIP AHCCCS Member Service Request form must also be returned to the AzEIP service coordinator indicating the services were determined not medically necessary.
   c. An examination by the PCP is needed to determine medical necessity:
      i. PHP will send a Notice of Action letter to the PCP, the AzEIP service coordinator, the member’s guardian/parent, and the AHCCCS MCH coordinator or designee denying the service pending examination by the PCP.
      ii. AzEIP AHCCCS Member Service Request form 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.
      iii. AHCCCS MCH coordinator 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.
      iv. After the member is examined by the PCP and a determination is made, steps 8.a. through 8.b. should be followed.
CHILDREN’S REHABILITATIVE SERVICES (CRS)

CRS is a program designed to serve Arizona children age 20 and younger who have medically handicapping or potentially handicapping conditions and have potential for improvement through various interventions.

PHP and PHP providers may refer children with potential CRS-eligible conditions to the CRS program. Referrals to AHCCCS for CRS must include the following:

- Complete the AHCCCS CRS application
- Copy of the medical record which supports the diagnosis of the eligible condition.

The philosophy of the CRS Program is based upon an individual's need for treatment of CRS eligible conditions through medical, surgical or therapy modalities where the following three criteria are present:

- Functional improvement is potentially achievable
- Long term follow-up may be required for maximum achievable results
- Specialized treatment is necessary

Examples of medical conditions that are covered under the CRS Program include the following:

- Cerebral Palsy
- Cleft Lip/Cleft Palate
- Cystic Fibrosis
- Metabolic Disease (Phenylketonuria, galactosemia, homocystinuria, hypothyroidism)
- Myelomeningocele (Spina Bifida)
- Neurofibromatosis
- Scoliosis
- Sickle Cell Anemia

For more information on CRS, go to the AMPM, Chapter 330 on the AHCCCS website at:


If you have any questions regarding CRS coverage or need assistance with the referral process, please contact PHP Case Management.
OUTREACH AND EDUCATIONAL PROGRAMS

PHP has many outreach and educational programs to assist our EPSDT members. For further information on any of these programs, please contact the MCH Coordinator.

**Perinatal Case Management Program**

The purpose of the perinatal case management program is to improve birth outcomes through education and support of the member during the pregnancy and in the postpartum period. A member is referred to the program when a total OB authorization is issued. Each member is assessed for risk from information provided on the ACOG and on the prior authorization form.

Members who are determined to be high risk are followed throughout their pregnancy through written outreach and phone contact. Substance abusing women will be referred to PHP behavioral health coordinator for referral to the appropriate RBHA.

**Childbirth Classes**

Childbirth classes are a covered service for PHP members at designated hospital facilities.

**Pediatric Asthma Education**

PHP offers disease management and asthma education for both members with asthma and their families. The goal of the disease management program is to educate the members and their families on how to manage the child's asthma.

The target population includes members who have frequent hospital admissions and/or ED visits, non-compliance with controller medications or poorly controlled asthma. We encourage providers to take advantage of this program and to refer pediatric asthma patients to this program. Please call the Disease Management coordinators for information or to refer a member to the asthma program.