Chapter 5

HEALTH SERVICES

The Comprehensive Medical and Dental Program provides full coverage for medical and dental services necessary to achieve and maintain the optimal level of health for children in out-of-home care. Covered services are based upon a determination of medical necessity and clinical appropriateness.

Covered Services

Covered services include, but are not limited to, the following medical services:

- Doctor office visits
- Well child check-ups, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), adolescent screenings, and treatment
- Immunizations
- Behavioral health services *(see Chapter 6)*
- Hospital services
- Specialist care, as needed
- Family planning services
- Well-Woman Preventative Services
- Rehabilitative services such as physical, occupational, and speech therapies
- Home and community-based services
- Laboratory and x-ray services
- Pregnancy care
- Emergency medical care
- Dental care
- Emergency transportation
- Vision care and eyeglasses
- Audiology services and hearing aids
- Medically needed transportation
- Pharmacy services, medical supplies, and equipment
- Nutritional assessments and nutritional therapy
- Nursing Facility services
- Hospice services

CMDP supports providers in following the American Academy of Pediatrics (AAP) Recommendations for Clinical Care that were outlined in the AAP policy statement: Health Care Issues for Children and Adolescents in Foster Care and Kinship Care, from October 2015. These recommendations outline an enhanced visit schedule and close follow up, as well as providing guidelines in the care of children in out-of-home care. This policy can be found at:

http://pediatrics.aappublications.org/content/136/4/e1131

http://pediatrics.aappublications.org/content/136/4/e1142

Non-Covered Services

Non-covered services include, but are not limited to:

- Any hospital admission, service, or item requiring prior authorization for which prior authorization has not been obtained;
- Pregnancy terminations that are not medically necessary;
- Pregnancy termination counseling for the purpose of family planning;
- Services or items for cosmetic purposes;
- Services or items furnished free of charge, or for which charges are not usually made;
- Services determined by CMDP to be experimental or provided primarily for the purpose of research;
- Services of private or special duty nurses other than when medically necessary and prior authorized;
- Physical, occupational, or speech therapy as a maintenance regimen only;
- Routine circumcision for an eligible newborn male infant, unless medical necessity is documented;
- Care for Temporomandibular Joint (TMJ) related disorders, unless determined medically necessary;
- Medical services to an inmate of any public institution or state mental health facility;
- Outpatient or inpatient psychiatric, psychological, or other counseling services provided to AHCCCS eligible children residing in Arizona—these services are provided through the Regional Behavioral Health Authorities (RBHAs);
- That portion of the cost of any covered service, which exceeds allowable charges in the CMDP fee schedule. Determination and payment **shall represent PAYMENT IN FULL for the services rendered. Any additional charge to the caregiver is prohibited by law.**
- The cost of care, services or items in excess of that paid by other programs.
- Services for which claims have not been re-submitted within 12 months of the date of service;
- Care provided by individuals who are not properly licensed and/or certified;
- Care provided by individuals who are not AHCCCS registered; and
- Treatment of the basic conditions of alcoholism and drug addiction. Alcohol and substance abuse treatment is an AHCCCS covered service that AHCCCS-eligible members should receive from the RBHA.

Notification Requirements

CMDP notifications are required in the following circumstances:

- All ED visits, within 24 hours of the visit
  All notifications must contain
  - Member name and date of birth
  - Facility name and Tax ID Number(TIN)
  - Admitting/attending physician
  - Description of admitting diagnosis, or ICD-10 or diagnosis code
  - Admission date

- All inpatient admissions, within 24 hours of admission
  All notifications must contain
  - Member name and date of birth

- Facility name and Tax ID Number (TIN)
- Admitting/attending physician
- Description of admitting diagnosis, or ICD-10 or diagnosis code
- Admission date

- All surgeries
  All notifications must contain
  - Member name and date of birth
  - Facility name and Tax ID Number (TIN)
  - Admitting/attending physician/surgeon name and TIN
  - Description of surgery, admitting diagnosis, or ICD-10 or diagnosis code
  - Admission date

- All delivery admissions
  All notifications must contain
  - Member name and date of birth
  - Facility name and Tax ID Number
  - Admitting/attending physician
  - Description of admitting diagnosis, or ICD-10 or diagnosis code
  - Admission date
  - Date of birth of newborn
  - Birth weight
  - Gender
  - Gestational age
  - Any congenital defect
  - Other diagnosis codes applicable to the newborn

- All Newborn admissions
  All notifications must contain
  - Facility name and Tax ID Number
  - Admitting/attending physician/Neonatologist
  - Description of admitting diagnosis, or ICD-10 or diagnosis code
  - Admission date
  - Date of birth of newborn
  - Birth weight
  - Gender
  - Gestational age
  - Any congenital defect
  - Other diagnosis codes applicable to the newborn

- Members who miss their EPSDT or routine dental visit
  All notifications must contain
  - Member name and date of birth
  - Facility name and Tax ID Number(TIN)
  - Admitting/attending physician
  - Date of missed service
  - Service missed

Prior Authorization Requirements and PA Matrix

Please refer to the CMDP website at https://dcs.az.gov/cmdp for the most up-to-date version of the *Prior Authorization (PA) Matrix*.

Service Type	PA Required	PA Not Required
Behavioral Health		
• Behavioral Health Hospital Inpatient Admission, • Behavioral Health Inpatient Facility, • Behavioral Health Residential Facility, • Brief Intervention Program (BIP) • Home Care Training to Home Care Client (HCTC)	Requires PA with supporting documentation and clinical discussion in Clinical Review to determine medical necessity. For **Title XIX and Title XXI members**, behavioral health services are provided through the RBHA. For **State Only or Non-TXIX members**, CMDP provides Clinical Review of medical necessity for all facility-based behavioral health services.	
Psychological	Requires PA with supporting documentation and clinical discussion in Clinical Review to determine medical necessity. For **Title XIX and Title XXI members**, behavioral health services are provided through the RBHA. For **State Only or Non-TXIX members,** CMDP provides all behavioral health services.	
Outpatient Behavioral Health Services including Psychiatry, Therapy, Counseling, Nursing Support Services, Behavior Coaching, Meet Me Where I Am		No PA required.
Behavioral Health Respite	PA required, 720 maximum hours allotted per member per year.	

Service Type	PA Required	PA Not Required
Psychotropic Prescriptions	Prescriptions from RBHA providers must be filled at RBHA contracted pharmacies using the member's RBHA ID number. For non-Title XIX (state only) eligible members, refer to CMDP's Preferred Drug List (PDL) for current information about covered psychotropic medications and PA requirements. All psychotropic medications for children under the age of 6 years require a PA. PA is required for more than one anxiolytic medications	PCP may write prescriptions for patients with minor depression, anxiety disorders, and treatment of ADHD without co-morbidity. See the Behavioral Health Tool Kit on the CMDP website.
Dental		
Dental		The American Association of Pediatric Dentistry recommends dental visits begin by age 1. Routine and preventive dental services do not require PA. CMDP allows 2 oral examinations and 2 oral prophylaxis and fluoride treatments per member per year (i.e. 1 every 6 months). Emergency services to relieve pain, suffering, or infection, do not require PA. May be retrospectively reviewed.
Orthodontics	PA required for all services, including the preorthodontic treatment visit. Submit documentation to support medical necessity.	Refer to the Dental Matrix for fees and services. This matrix is available on the CMDP website https://dcs.az.gov/cmdp.
Orthognathic surgery	PA required to determine if patient is CRS enrolled or eligible.	
Other Dental: Periodontal procedures, bridge and crown restoration, root canals	PA required. Must submit documentation to support medical necessity and include x-rays.	

Service Type	PA Required	PA Not Required
Other		
Durable Medical Equipment (DME) and Supplies, Prosthetics and Orthotics	PA required for all rentals. Total cost of the rentals must not exceed the purchase price. Purchases valued at $300 or more require PA. Nutritional supplements/formulas require PA, a current prescription, and completion of the "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements Form."	Medically necessary items following hospital discharge for a period of 30 days or less and equipment ordered on an emergency basis for short-term use do not require PA.
Emergency Department and Urgent Care Services		No PA required. CMDP requests notification within 24 hours of ED visit for case management purposes.
Family Planning	PA required for surgical interventions.	This includes emergency contraception. IUDs do not require PA. STD and HIV/AIDS testing do not require a PA. See HIV Testing section below.
HIV Testing		HIV/AIDS testing does not require PA. **HIV testing requires signed consent by the child's custodial agency if the child is 12 years of age or younger, children age 13 + may self-consent.**
Home Health/Hospice	Requires PA and documentation to support medical necessity. Written plan of care must accompany the request.	
Inpatient Services	Notification to CMDP required within first 24 hours.	
Obstetrical Services (OB)	PA and American College of Obstetricians and Gynecologists (ACOG) Health Record required for OB package authorization. OB package includes: prenatal visits, ultrasounds, delivery, and postpartum visit. Any further testing requires separate PA.	

Service Type	PA Required	PA Not Required
Pregnancy Termination	Requires PA and must meet AHCCCS guidelines and have proper documentation to support the request. The child's custodial agency representative must provide or obtain proper consents.	
Synagis, Growth Hormones	Requires PA and documentation to support medical necessity. Refer to the Preferred Drug List (PDL) at https://dcs.az.gov/cmdp.	
Anti-Hemophiliac Medications	Requires PA. Contact Health Services for arrangements.	
Psychotropic Medications	See Behavioral Health section above regarding psychotropic medications. All psychotropic medications for children under 6 years of age require PA.	
Diapers	Diapers require PA and documentation to support medical necessity. Diapers for members over the age of 3 must meet AHCCCS criteria.	
OTC Meds		OTCs do not require a PA but must be written on a prescription from a provider.
Medication not on PDL (CMDP formulary)	Any medication not on the PDL requires PA and documentation to support medical necessity.	As a rule, most generic medications are covered. In some instances AHCCCS has designated a particular brand as the preferred drug- please consult the PDL formulary. https://dcs.az.gov/cmdp
Specialist Referrals	Treatment beyond the initial consultation requires PA. Include documentation to support medical necessity and plan of care.	Initial consultation does not require PA, but obtain referral from child's PCP. Application and/or removal of casts and splints does not require PA.
Transportation		
Emergency		CMDP requests notification within 10 days of service for case management purposes.

Service Type	PA Required	PA Not Required
Medically Necessary – Non-Emergent	Contact the child's custodial agency initially. If all other means of obtaining transportation are unsuccessful, the child's custodial agency must contact CMDP. After contacting the child's custodial agency, the custodial agency representative must notify Member Services for arrangements and authorization. An adult must accompany the child.	
Vision Services		
Eyeglasses	Sports glasses and tinted lenses require PA and documentation to support medical necessity.	Frames, lenses, and scratch coating do not require a PA if the cost is within the AHCCCS fee schedule. Bifocals and repairs do not require a PA.
Contact Lenses	Requires PA and documentation to support medical necessity.	

All routine medically necessary vaccines are covered under the Vaccines for Children (VFC) Program. If billing for a non-VFC vaccine, please submit documentation of medical necessity.

Providers must bill using both the immunization administration CPT codes and the vaccine CPT codes when billing for vaccines under the federal VFC Program. *See Chapter 9 for more information on VFC Program billing.*

Dental

CMDP covers all AHCCCS covered dental services for members. This includes preventive and restorative care. An oral health screening should be part of an EPSDT screening done by a PCP. It does not take the place of an exam done by a dentist. Members do not need a referral from their PCP and can see any dentist listed in the Provider Directory. The American Academy of Pediatric Dentistry recommends dental visits begin by the age of **1 year old**. All members by the age of 3 should see the dentist **twice a year for routine exams, and more often if needed**. Routine dental services are covered by CMDP. A dentist needs prior approval for major dental services.

The following is a list of covered dental services:

- Dental exams and x-rays
- Treatment for pain, infection, swelling and dental injuries
- Cleanings and fluoride treatments
- Dental sealants

- Fillings, extractions, and medically necessary crowns
- Pulp therapy and root canals
- Dental education

Dentists are part of the CMDP Preferred Provider Network (PPN). Contact Provider Services to inquire about PPN dentists.

CMDP must receive complete and accurate records for reviewing services requiring prior authorization. This will assist the dental consultant, who is a state-licensed dentist, in making an appropriate determination. Refer to the *CMDP Dental Matrix on the* CMDP website for the list of eligible dental services and prior authorization requirements. Determination of prior authorization must be in writing and must be granted ***before*** the proposed procedure is begun. Denial of prior authorization and member non-eligibility on the date of service will result in denial of reimbursement.

Orthodontia

CMDP covers orthodontia if it is medically necessary and meets specific criteria. Orthodontic services require medical necessity for the purpose of controlling or eliminating infection, pain, and disease, and restoring facial configuration or function necessary for speech, swallowing, or chewing. The *Dentist's Certification of Medical Necessity (CSO-1006A),* found at the end of this chapter, must be completed and signed to request orthodontic treatment.

A member must meet the medical and social criteria in order for CMDP to approve orthodontic services. Social criteria are detailed by a DCS specialist via the Consideration Factors for Orthodontic Services (CSO-1191A) form. Medical criteria are indicated by the PCP via the PCP Statement of Medical Necessity (CSO-1184A) form.

CMDP must receive complete and accurate records for reviewing services requiring prior authorization. This will assist the dental consultant, who is a state licensed dentist, in making an appropriate determination. Refer to the *CMDP Dental Matrix* for the list of eligible dental services and prior authorization requirements. Prior authorization is necessary for the pre-orthodontic visit, appropriate tracings, photographs, and orthodontia models, prior to submitting the request for orthodontia. Determination of prior authorization must be in writing and must be granted before the proposed procedure is begun. Denial of prior authorization and member non-eligibility on the date of service will result in denial of reimbursement.

Payment for orthodontia treatments may only be made for children who are continuing members of CMDP. The child's placement is not financially responsible for the remaining cost of services. The dentist is responsible for verifying the child's enrollment status at the time of treatment.

Orthodontists are part of the CMDP PPN. Contact Provider Services to inquire about PPN orthodontists.

Charges are reimbursed according to the AHCCCS Fee-for-Service Schedule.

Contact Health Services for any forms or questions, at (602) 351-2245 or (800) 201-1795.

Emergency Services

CMDP covers emergency medical services provided by qualified medical professionals for all members, as specified in Arizona Administrative Code (A.A.C.) R9-22-210. Emergency medical services are those services provided after the sudden onset of an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could be expected to result in:

- Placing the member's health in serious jeopardy,
- Serious impairment of bodily functions, or
- Serious dysfunction of any bodily organ or part.

For utilization review purposes, the test for appropriateness of the request for emergency services is whether a prudent layperson, if in a similar situation, would have requested such services.

Emergency medical services covered without prior authorization include, but are not limited to, all medical services necessary to rule out an emergency condition and emergency transportation. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge. The transfer or discharge plan shall incorporate aftercare of the member's medical and behavioral health needs.

CMDP monitors emergency service utilization by both providers and members, and has established guidelines for addressing inappropriate use.

Per the Balanced Budget Act of 1997, and 42 CFR 438.114, CMDP may not deny payment for treatment obtained under either of the following circumstances:

- A member had an emergency medical condition, including cases in which the absence of medical attention would not have resulted in the outcomes identified in the definition of emergency medical condition (42 CFR 438.114).
- A representative of CMDP instructs the member to seek emergency medical services.

Additionally, CMDP may not:

- Limit what constitutes an emergency medical condition as defined in 42 CFR 438.114, on the basis of lists of diagnoses or symptoms.
- Refuse to cover emergency services based on the failure of the provider, hospital, or fiscal agent to notify CMDP of the member's screening and treatment within 10 calendar days of presentation for emergency services. This notification stipulation is only related to the provision of emergency services.

A member who has an emergency medical condition may not be held liable for payment of emergency services, or subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

EPSDT

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services are a comprehensive child health program of prevention and treatment, correction, and improvement (amelioration) of physical and mental health problems for AHCCCS members under the age of 21. The purpose of EPSDT is to ensure the availability and accessibility of health care resources, as well as to assist Medicaid recipients 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 problems for AHCCCS members less than 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services, and all other medically necessary mandatory and optional services listed in federal law 42 USC 1396d(a) to correct or ameliorate defects and physical and 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 and includes all screenings and services described in the AHCCCS EPSDT and dental periodicity schedules.

Amount, Duration, and Scope

The Medicaid Act defines EPSDT services to include screening services, vision services, dental services, hearing services, and "such other necessary health care, diagnostic services, treatment and other measures described in federal law subsection 42 USC 1396d (a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the (AHCCCS) state plan." This means that EPSDT covered services include services that correct or ameliorate physical and mental defects, conditions, and illnesses discovered by the screening process when those services fall within 1 of the 29 optional and mandatory categories of "medical assistance" as defined in the Medicaid Act. Services covered under EPSDT include all 29 categories of services in the federal law even when they are not listed as covered services in the AHCCCS state plan, AHCCCS statutes, rules, or policies as long as the services are medically necessary and cost effective.

EPSDT includes, but is not limited to, coverage of: inpatient and outpatient hospital services, laboratory and x-ray services, physician services, nurse practitioner services, medications, dental services, therapy services, behavioral health services, medical supplies, prosthetic devices, eyeglasses, transportation, and family planning services. EPSDT also includes diagnostic, screening, preventive, and rehabilitative services. However, EPSDT services do not include services that are solely for cosmetic purposes, or that are not cost effective when compared to other interventions.

EPSDT Screening Requirements

Comprehensive periodic screenings must be conducted according to the timeframes identified in the periodicity schedule, and inter-periodic screenings must be completed as appropriate for each member. The periodicity schedule is based on federal mandates and is closely aligned to Arizona Medical Association (AMA) and American Academy of Pediatrics (AAP) guidelines. Providers must provide health screening in compliance with the AHCCCS EPSDT periodicity schedule and the AHCCCS Dental Periodicity Schedule (AHCCCS Exhibit 430-1 and 431-1). The following is a summary of what is included in EPSDT screens. Additional information may be obtained from CMDP Health Services.

- A comprehensive health and developmental history (including physical, nutritional, and behavioral health assessments).
- A comprehensive unclothed physical examination.
- Appropriate immunizations according to age and health history. **NOTE:** The immunization schedule can be viewed on the CMDP website at https://dcs.az.gov/services/comprehensive-medical-dental-program-cmdp/members.
- Laboratory tests (including blood lead screening assessment appropriate to age and risk, tuberculosis screening appropriate to age and risk, anemia testing and, if appropriate, diagnostic testing for sickle cell trait, the Newborn Screen for all infants, STD, and other testing as appropriate).
- Health education.
- Appropriate dental screening.
- Appropriate vision, hearing, and speech testing.
- Developmental screening.
- Immunizations. Providers must be registered with the Vaccines for Children (VFC) Program. VFC vaccines must be used for children in CMDP. The Arizona Department of Health Services (ADHS) manages the VFC Program. ADHS operates the Arizona State Immunization Information System (ASIIS), a registry designed to collect immunization data on individuals within the state. Providers must record all the vaccines administered to CMDP members in the ASIIS registry. If you need assistance with ASIIS, call them at (877) 491-5741 to learn about the system and how to obtain the web-based program to connect your office to ASIIS.

EPSDT providers are asked to complete the screenings listed for each period and complete the EPSDT Tracking Form appropriate to the age of the child. Additional tracking forms may be obtained from your CMDP Provider Services Representative or on the CMDP website. CMDP staff will review EPSDT tracking forms for completeness and quality, identify referrals made for evaluation and treatment and missed opportunities for immunizations. CMDP staff may contact provider offices to schedule a record audit of EPSDT services and offer provider education about the program.

Providers are requested to notify CMDP Member Services when CMDP members fail to make or keep EPSDT appointments.

Well- Woman Preventative Care Services

CMDP members are all children under 18 years of age, in out-of-home (foster) care.

Well- Woman Preventative Care services are an integral part of the EPSDT visit for age- and developmentally- appropriate members, or are done when the member chooses an OB/GYN for their PCP.

AHCCCS defines Well- Woman Preventative Care visit as a covered benefit of women to obtain recommended Preventative Services including pre-conception counseling. This visit is intended to

- Identify risk factors for disease
- Identify existing medical/mental health problems and
- Promotion of healthy lifestyle habits essential to reducing or preventing risk factors for various disease processes.

A Well- Woman Preventative visit is inclusive of a minimum of the following

- A Physical (well exam)
- Clinical Breast Exam
- Pelvic exam (if necessary based on current recommendations and best practice)
- Review and administration of immunizations, screening and testing as appropriate for age
- Screening and counseling focused on maintaining a healthy lifestyle and minimizing health risks which include
    - Proper Nutrition
    - Physical Activity
    - Elevated BMI indicative of obesity
    - Tobacco/substance use, abuse and/or dependency
    - Depression screening
    - Interpersonal and intimate partner violence screening
    - Sexually transmitted infections (STIs)
    - HIV
    - Family Planning Counselling
    - Preconception counseling that includes discussion regarding healthy lifestyle before and between pregnancies that includes
        - Reproductive history and sexual practices
        - Healthy weight, including diet and nutrition, use of folic acid and nutritional supplements
        - Physical Activity or exercise
        - Oral Health Care
        - Chronic Disease Management
        - Emotional Wellness
        - Tobacco and substance use, including prescription drug use
        - Recommended interval between pregnancies
        - Initiation of referrals as needed.

As PCPs will no doubt notice- these are all aspects of the EPSDT visit for Teens- with particular attention to Pre-conception counseling. PCPs will need to assess the age- and developmental- readiness of the members when addressing these issues, especially for children in CMDP who may have suffered neglect or abuse that may affect the discussion on the topics above.

Developmental Screening Using the PEDS Tool, Ages and Stages Questionnaire (ASQ), or the Modified Checklist for Autism in Toddlers (MCHAT) Tool

Use of the Parent's Evaluation of Developmental Status (PEDS) tool for other health plans is limited to infants born after January 1, 2006 who have had stays in the Newborn Intensive Care Unit (NICU). For CMDP members only, the tool may be used to screen all infants and children up to the age of 8 who are at risk or identified as having developmental delays. These children may be screened at each EPSDT visit. Providers who bill for this service must complete training on the use of the tool and **must submit the PEDS Tool Score Form and PEDS Tool Interpretation Form** with the EPSDT Tracking Form and claim form for reimbursement of services.

Providers can utilize an online PEDS tool training session provided by the Arizona Chapter of the American Academy of Pediatrics (AzAAP) at https://www.azpedialearning.org/courses. Providers who complete the training may bill CMDP for use of the tool.

CMDP requirements for reimbursement of the developmental screen are as follows:

- Verified completion of the PEDS tool training program;
- For CMDP members only, the tool may be used to screen children up to the age of 8 who are at risk or identified with developmental delays; and
- Copies of the PEDS Tool Score and Interpretation forms, the MCHAT and the ASQ forms are submitted in the same manner that the EPSDT tracking forms are submitted with the CMS 1500 claim form.

Use billing code 96110 with an EP modifier. Refer to the AHCCCS Fee-for-Service web page for reimbursement rates (https://azahcccs.gov/PlansProviders/RatesAndBilling/FFS/Physicianrates/). For questions, please contact Provider Services at (602) 351-2245 or (800) 201-1795.

Arizona State Immunization Information System (ASIIS)

By state law, all providers are required to be connected to the Arizona State Immunization Information System (ASIIS), and to report to this system all immunizations administered. **Provider staff should enter all immunization data timely and completely to comply with state laws and eliminate unnecessary revaccinations.**

ASIIS allows providers to query immunization records on individual children or groups of children. In addition, it generates reminder notices for the provider to indicate when immunizations are due or past due for individual children. CMDP also has access to ASIIS to verify immunization records.

Contact ASIIS directly at (877) 491-5741 for information on the ASIIS software program or instructions on using the web-based system. ASIIS will provide hands-on training for providers.

Providers who are unable to determine a child's immunization status may contact the EPSDT Coordinator at CMDP Health Services. We will make every effort to verify the immunization history in question.

Maternal Health/Family Planning

Family Planning

Family planning services are covered services for CMDP members. Members aged 12 and older must be notified each year of available family planning services, verbally by their PCP or Primary Care Obstetrician (PCO), and in writing by CMDP. Members may receive the following medical, surgical, pharmacological, and laboratory family planning services:

- Natural family planning education, counseling, and referral to qualified health professionals, including information on the prevention and spread of sexually transmitted diseases (STDs).
- **STD testing, not limited to chlamydia and including HIV testing. HIV testing requires signed consent from the member's custodial agency representative if the child is 12 years or younger. If the child is 13 years of age or older, he/she may consent to HIV testing.**
- Intrauterine devices (IUDs).
- Associated medical and laboratory examinations including ultrasound studies related to family planning, physical exams, and pelvic exams.
- Treatment of complications resulting from contraceptive use, including emergency treatment.

- Post coital emergency oral contraception within 72 hours after unprotected sexual intercourse.

Pre-Teen Vaccine Campaign

ALL 11 and 12-year-olds should receieve the Tdap, Meningococcal and HPV vaccines. All of these vaccines are covered through the VFC Program.

In addition, please check the status of the the member's childhood immunizations during the pre-teen EPSDT visit to make sure they get any vaccines they may have missed, which include but are not limited to:

- Hepatitis B
- Measles, Mumps, and Rubella
- Polio
- Varicella

Prenatal Care

CMDP is the health plan for children in out-of-home care. Due to the age of our members, pregnant CMDP members are considered at risk. Pregnant members must be referred to a Primary Care Obstetrician (PCO) as soon as the pregnancy is confirmed. Call CMDP Provider Services at (602) 351-2245 or (800) 201-1795 for assistance in locating a PCO. CMDP clinical staff will assist providers in coordinating care and services for the pregnant member. Notify the CMDP Maternal Health Coordinator (MHC) of the pregnancy to obtain prior authorization for prenatal care. PA requests for total obstetrical (OB) care must include a copy of the ACOG form. Please instruct pregnant members to call their custodial agency representative or CMDP Health Services for any assistance.

Prenatal Care Appointment Timeframes

Providers must have initial prenatal care appointments within the established timeframes. The established timeframes are as follows:

a. First trimester – within 14 days of a request for an appointment

b. Second trimester – within 7 days of a request for an appointment

c. Third trimester – within 3 days of a request for an appointment

d. High-risk pregnancy care must be initiated within 3 days of identification to CMDP or maternity care provider, or immediately if an emergency exists.

Maternity care includes medically necessary services for the care of pregnancy, treatment of pregnancy-related conditions, antepartum services, and postpartum care. Access to low cost/no cost family planning services is available after members leave CMDP.

As an AHCCCS contractor, we are obligated to ensure that AHCCCS network providers adhere to AHCCCS requirements as defined in Policy 410-D-3 a-h, of the AHCCCS Medical Policy Manual (AMPM). Perinatal/postpartum depression screenings must be conducted 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 (AHCCCS, 2016). A validated depression tool should be used for the assessment.

Providers should refer to AMPM, Exhibit F: Tool Kit for the Management of Adult Postpartum Depression, which is intended to assist the provider in assessing the postpartum needs of women regarding depression and decisions regarding health care services provided by the PCP or subsequent referral to the Regional Behavioral Health Authority (RBHA) if clinically indicated.

Pregnancy Termination

Pregnancy termination (including the use of Mifepristone) is a covered service for CMDP members if 1 of the following conditions exists:

- The pregnant member suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by, or arising from, the pregnancy itself that would, as certified by a physician, place the member in danger of death, unless the pregnancy is terminated.
- The pregnancy is a result of 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; or,
  - Preventing the pregnant member from obtaining treatment for a health problem.

Prior authorization (PA) is required from the CMDP Chief Medical Officer before performing a pregnancy termination, including provision of mifepristone. To obtain PA, the attending physician must complete the AHCCCS Certificate of Medical Necessity for Pregnancy Termination Form (a web link to the form is available at the end of this chapter; the form may be photocopied) certifying that, in the physician's professional judgment, 1 or more of the above criteria have been met. The completed and signed form must be faxed to CMDP Health Services, with a copy of an informed consent form for the termination, signed by the CMDP member if 18 years or older.

If the member is under age 18, or is 18 years of age or older and considered an incapacitated adult, a dated signature of the member's parent or legal guardian indicating approval of the pregnancy termination procedure is required. The following documentation must accompany the AHCCCS Certificate of Medical Necessity for Pregnancy Termination Form.

- When the pregnancy is the result of rape or incest, documentation that the incident was reported to the proper authorities, including the name of the agency, report number, and the date the report was filed.
- Signature of the legal guardian approving the termination procedure and copy of the court order if someone other than the legal guardian has been given authorization to approve the termination procedure.

In medical emergencies, the provider must submit all documentation of medical necessity to CMDP within 2 working days of the date on which the termination of pregnancy procedure was performed.

Hysterectomy

Hysterectomy or other means of sterilization is not covered unless medically necessary. Prior authorization is required. If the procedure can be substantiated as medically necessary, in addition to the supporting medical documentation, the following requirements must also be met:

- The member and legal guardian must sign a consent form, which includes information that the hysterectomy will render her incapable of bearing children. Providers may use the sample AHCCCS hysterectomy consent form in this chapter.
- The provider is not required to complete a consent to sterilization form prior to performing hysterectomy procedures and the 30 day waiting period required for sterilization does not apply to hysterectomy procedures.
- Unless an emergency, a second opinion may be required.
- In an emergency, PA is not required, but the physician must certify in writing that an emergency or life-threatening illness or disease exists.

Contact Medical Services for assistance in obtaining the necessary prior authorization at (602) 351-2245 or (800) 201-1795.

Pharmacy

In order to maintain the quality and cost-effectiveness of the pharmacy benefit program, CMDP has implemented a Preferred Drug List (PDL). This PDL (sometimes referred to as a formulary) is a list of medications preferred by CMDP. All the medications on the PDL have received U.S. Food and Drug Administration (FDA) approval as safe and effective. A committee of physicians and pharmacists has chosen all medications on this list.

Use the PDL to locate brand and generic medication alternatives that are covered under the CMDP plan. Some medications or classes require prior authorization and/or have a limited allowable quantity. These are shown on the PDL. Please complete the *Prior Authorization for Medications (CMD-026-C)* for all requests for non-formulary medications. Medications that are experimental and/or investigational in nature are not covered.

NOTE: For assistance with prior authorization, please refer to the PDL or contact Health Services. The PDL can be accessed on the CMDP website at https://dcs.az.gov/cmdp.

CMDP's formulary mirrors the AHCCCS preferred Drug list. Generic substitution wherever allowed is encouraged. AHCCCS has stipulated certain brand name drugs as preferred drugs. If an alternate drug to the PDL must be prescribed, documentation to support the specific drug must be submitted to CMDP Health Services for prior authorization.

Over-the-counter (OTC) medications may be covered, when prescribed by a provider. Note that all prescriptions are required to be written on tamper-proof prescription pads or electronically prescribed. If you have questions, contact CMDP Health Services at (602) 351-2245 or (800) 201-1795.

Psychotropic medications for limited behavioral health diagnoses *(see Chapter 6)* may be prescribed

by a PCP. Prescriptions written by a RBHA psychiatrist for a Medicaid eligible member must be filled through RBHA contracted pharmacies, using the RBHA identification number. Medications to treat major depressive disorders must be obtained through the RBHA providers. RBHA enrolled members receive their medications through the RBHA. Contact the Health Services Behavioral Health Coordinator for assistance.

Refills

CMDP members are children in out-of-home care. Due to the frequent transition of CMDP members to different placements, physicians may be requested to write new prescriptions for drugs before the previous supply has expired. Physicians are requested to comply with these requests, yet be aware of attempts to fraudulently obtain drugs. Suspected attempts to obtain drugs fraudulently must be immediately reported to CMDP Provider Services at (602) 351-2245 or (800) 201-1795.

Lock-In Service

The Lock-In Service is available for members who qualify. This Program limits members to 1 pharmacy and 1 prescriber for non-emergency controlled substance prescriptions. Assignment of members to an exclusive pharmacy and/or single provider must meet the following criteria:

- Utilizing the following in a 3-month time period
  - 4 prescribers
  - 4 different drugs that have the potential for abuse
  - 4 pharmacies
- Presenting a forged or altered prescription to the pharmacy; or
- Receiving 12 or more prescriptions of the following medications with the exception of those members with an oncology diagnosis, those in hospice care, or those in a skilled nursing facility.
  - Atypical antipsychotics
  - Benzodiazepines
  - Hypnotics
  - Muscle relaxants
  - Opioids
  - Stimulants

Therapies (Occupational Therapy, Physical Therapy, Speech Therapy, Audiology Services, Respiratory Therapy)

CMDP covers therapies that are medically necessary to improve or restore functions that have been impaired by illness, injury, or disability. CMDP Health Services authorizes therapy services in the amount, frequency, and duration as are determined medically necessary and clinically appropriate. Authorization determinations are based on the AHCCCS Medical Policy Manual. If the member is enrolled in CRS, CMDP coordinates therapy benefits with CRS. CMDP also pays for medically necessary therapies arranged through the Arizona Early Intervention Program (AzEIP) which follows the normal Prior Authorization (PA) request process.

A prior authorization is not required for a therapy evaluation. However, actual therapy services require PA.

For authorization to provide therapy, either the therapist or the PCP/specialist must document and submit in writing to CMDP the evaluation results and treatment plan, including goals, rehabilitation potential, location of services (home or office), length of time (from and through dates), and number of sessions requested. Continued authorization will require the PCP/specialist's statement of medical necessity and submission of the therapist's progress notes and/or updated evaluation with new treatment plan. The number of visits cannot exceed member's eligibility span.

Transplants

Providers must obtain prior authorization from CMDP for all organ and tissue transplantation services. All transplant services are coordinated by CMDP with the AHCCCS Division of Health Care Management and the services of AHCCCS contracted transplant specialists, when available.

CMDP covers medically necessary transplantation services as outlined by AHCCCS, and related immunosuppressant medications. Covered transplants must be non-experimental and non-investigational for the specific organ/tissue and specific medical condition. Solid organ transplantation services must be provided in a Centers for Medicare and Medicaid Services (CMS) certified and United Network for Organ Sharing (UNOS) approved transplant center that is contracted with AHCCCS, unless otherwise approved by the AHCCCS Chief Medical Officer or designee. Bone marrow transplantation services should be provided in a facility which has achieved Foundation for the Accreditation of Cellular Therapy (FACT) accreditation as a bone marrow transplant center and that is contracted with AHCCCS, unless otherwise approved by the AHCCCS Chief Medical Officer or designee.

Due to emotional distress that may come from the transplant process, CMDP's Behavioral Health unit is available to assist with behavioral health care coordination.

Questions regarding coverage and procedures for transplants or behavioral health services should be immediately directed to CMDP Health Services at (602) 351-2245 or (800) 201-1795.

Hospital Utilization

CMDP's inpatient hospital services refer to those medically necessary services provided by, or under the direction of, a Primary Care Physician, practitioner, or a specialty physician on referral from a Primary Care Physician, which are ordinarily furnished in a hospital.

Concurrent review is performed on admission and at frequent intervals during inpatient hospital stays. Reviews assess the appropriate usage of ancillary resources, levels of care (LOC), and service, according to professionally recognized standards of care using InterQual criteria. Concurrent review validates the medical necessity for continued stay and evaluates quality of care. Discharge planning begins upon admission.

Concurrent review is initiated within 1 business day of notification and continues at intervals appropriate to patient condition, based on the review findings. During review, the following are considered:

- Necessity of admission and appropriateness of service setting
- Quality of care
- Length of stay

- Discharge needs
- Utilization pattern analysis

CMDP uses AHCCCS payment methodology for payment. When a hospitalization is no longer medically necessary and the member no longer meets criteria for an acute inpatient stay, CMDP will issue a denial for the medical stay. If this occurs and the child is not discharged because an appropriate placement outside of the hospital is not available, CMDP may pay for a service that is called an "Administrative Day." CMDP may pay for additional Administrative Days after the medical necessity has been exhausted and the denial issued.

CMDP Health Services coordinates with the Medical Directors in determining the appropriateness of continued services, in consultation with physician advisors as necessary. Continued hospital services may be denied when:

- A member no longer meets intensity and severity criteria;
- A member is not making progress in a rehabilitative program; or
- A member can be transferred safely to a lower level of care.

Contact the Concurrent Review Nurse at CMDP Health Services with any inpatient concerns.

The hospital must notify CMDP Health Services within 24 hours of admission at (602) 351-2245 or (800) 201-1795.

Transportation

Emergency Transportation

Emergency transport by ground or air ambulance to the nearest clinically appropriate hospital or emergency department is covered if medically necessary based on the member's medical condition at time of transport, and if no other transport is appropriate and available. The ambulance provider must notify CMDP within 10 days of the transport or the claim may be denied. Use of emergency transportation for non-emergent reasons will not be paid.

Non-emergency Medically Necessary Transportation

Transportation to medical providers and pharmacies (for prescription drugs or medical supplies) is provided to CMDP members or caregivers who are unable to provide their own transportation.

Most CMDP members reside in licensed placements such as family homes, emergency shelters, and group homes. These licensed placements are expected, and in some cases required through contracts, to provide routine transportation and accompany the member to routine health care appointments. Licensed placements receive a monthly maintenance payment for routine transportation. The rate of the maintenance payment is adjusted when the needs of the member, including transportation, are greater than average. In some instances, a member's case manager or a case aide may accompany and transport a child to medical appointments. Given these alternatives, assistance from CMDP in providing routine transportation is rarely needed.

To request non-emergency, medically necessary transportation, contact CMDP Member Services and

be prepared to discuss the destination and reason for the transport. CMDP requires that a responsible adult accompany minors.

Transportation Standards

If a member needs non-emergency medically necessary transportation, CMDP requires its transportation provider to schedule the transportation so that the member arrives on time for the appointment, but no sooner than 1hour before the appointment; does not have to wait more than 1 hour after making the call to be picked up; and does not have to wait for more than 1 hour after conclusion of the appointment for transportation home.

Transportation to Behavioral Health Providers

Transportation to behavioral health providers is the responsibility of the RBHAs for Medicaid eligible members. CMDP is responsible for transporting the member to the first appointment to the RBHA, if necessary. If there are any questions about responsibility for transportation to behavioral health providers, contact the CMDP Behavioral Health Coordinator.

Any non-Medicaid eligible members receiving behavioral health services are eligible to receive medically necessary transportation services for behavioral health appointments through CMDP.

Medically Necessary Transportation Outside the Member's Service Area

For services that are only available outside the member's service area (generally the county), transportation may be reimbursed by CMDP. Additionally, meals and lodging may be reimbursed for the member and 1 attendant during the travel time required to the medical provider and again upon return home. Services of an attendant (responsible adult) may be reimbursed. These services must receive prior authorization. Contact Health Services with any questions.

Ambulance Transfer Between Medical Providers

Transfer by ambulance between medical providers (i.e. between treating hospitals or hospital to nursing facility) is covered with prior authorization from CMDP. The hospital requesting the transfer must contact the CMDP Concurrent Review Nurse to coordinate the transportation.

At a minimum, hospital to hospital or hospital to specialty only transportation should be reimbursed at the Basic Life Support rate. If the member's medical condition meets criteria for medical necessity, this could also be reimbursed at Advance Life Support rate.

Vision

CMDP covers vision care including refractions, eyeglasses, and care of medical conditions of the eye. Appointments for refractions do not require prior authorization. Eyeglasses meeting the conditions set forth in the *CMDP PA Guidelines* do not require PA. Repair and replacement of eyeglasses is covered.

Contact lenses are covered only when needed after cataract surgery or when determined medically necessary. Prescriptions for contact lenses require PA and must state why these are medically necessary instead of glasses.

Initial referral to an ophthalmologist does not require PA. Ongoing treatment does require prior authorization.

Children's Rehabilitative Services (CRS)

Children's Rehabilitative Services (CRS) is a carve-out program administered through AHCCCS, which provides diagnostic, surgical, hospitalization, rehabilitation, pharmacological, and allied services. CRS contracts with Arizona regional physicians who are experts in their fields to treat CRS enrolled patients.

Eligibility for CRS is based on specific medical illnesses, disabilities, congenital anomalies, or potentially disabling conditions that have the potential for functional improvement through medical, surgical, or therapeutic intervention. Most CMDP members are financially eligible for CRS; however, they must become enrolled with CRS to have a condition treated there. CMDP members must receive services for medically eligible conditions through CRS, unless they have a private insurance payer and/or Medicare.

CRS is not an acute care provider. Each CRS patient must have a PCP through CMDP to provide general care and immunizations. Infectious diseases and acute trauma are not treated by CRS unless there is a direct relationship between these and the CRS-eligible condition. The CRS Administration determines coverage through CRS.

Anyone may *refer* a child for CRS services. Application for services is by completion of the *CRS Pediatric History and Referral Form* and documentation of the child's primary diagnosis supporting the application. CMDP can complete the CRS application with the assistance of the child's custodial agency representative. Whenever possible, pertinent x-rays and test results and other related medical records should accompany the referral form.

The *Pediatric History and Referral Form* may be photocopied and used to initiate an application for CRS. Clean copies may be requested from CMDP.

For more information about specific eligible conditions and covered services, please contact CMDP Health Services. The unit will assist providers in identifying CMDP members who may be eligible for CRS. Once CRS determines the child medically eligible, the child is enrolled in CRS. CRS enrolled members must receive CRS covered services through CRS providers.

CHAPTER APPENDIX

AHCCCS Forms

www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap400.pdf

Arizona Health Care Cost Containment System (AHCCCS) Periodicity Schedules

- EPSDT Periodicity Schedule (Exhibit 430-1)
- Dental Periodicity Schedule (Exhibit 431-1)
- Vision Periodicity Schedule
- Hearing and Speech Periodicity Schedule

Recommended Childhood and Adolescent Immunization Schedules

- Ages 0-6 years
- Ages 7-18 years
- Children and adolescents who start late or who are more than 1 month behind

AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements
AHCCCS Certificate of Necessity for Pregnancy Termination
AHCCCS Exhibit F, Behavioral Health toolkits – Postpartum Depression
https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/AppendixF_PostpartumDepression.pdf

CMDP Forms

https://dcs.az.gov/data/dcs-forms

CSO-1176A	Physician's Certification of Medical Necessity
CSO-1175A	Prior Authorization for Therapies
CSO-1179A	Prior Authorization for Medical/Surgical Services
CSO-1177A	Prior Authorization for Medical Equipment and/or Supplies
CSO-1220A	MedImpact Prior Authorization for Medications
CSO-1204A	CMDP Family Planning Services
CSO-1006A	Dentist's Certification of Medical Necessity
CSO-1191A	Consideration Factors for Orthodontic Services
CSO-1184A	PCP Statement of Medical Necessity - Orthodontia

Other

AAP policy statement: Health Care Issues for Children and Adolescents in Foster Care and Kinship Care, October 2015

http://pediatrics.aappublications.org/content/136/4/e1131

AAP Technical Report: Health Care Issues for Children and Adolescents in Foster Care and Kinship Care, October 2015

http://pediatrics.aappublications.org/content/136/4/e1142