



Member Handbook

“The State of Arizona Serving Children in Care”



Revised August 2015

Table of Contents

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CMDP Communications Directory and Instructions	1
INTRODUCTION	4
WHAT IS CMDP?.....	4
AMERICAN INDIAN MEMBERS	4
CULTURAL COMPETENCY.....	4
LANGUAGE AND ORAL TRANSLATION SERVICES.....	5
MEMBER SERVICES	5
PROVIDER SERVICES.....	5
ELIGIBILITY AND ENROLLMENT.....	6
DUAL ELIGIBILITY	6
MEDICARE DRUG COVERAGE FOR BARBITURATES AND BENZODIAZEPINES.....	6
OTHER INSURANCE	7
MEDICAL COVERAGE FOR YOUNG ADULTS IN CARE.....	7
THE IDENTIFICATION (ID) CARD.....	7
MEMBER INFORMATION	8
MEDICAL HOME.....	8
CHOOSING A PRIMARY CARE PROVIDER (PCP) AND PRIMARY DENTAL PROVIDER (PDP).....	9
REASONS TO HAVE A PCP AND PDP:.....	9
CHANGING YOUR PCP/PDP	10
SEEING A SPECIALIST	10
MEDICAL/DENTAL APPOINTMENTS.....	10
COVERED SERVICES.....	11
INCONTINENT BRIEFS	11
PRIOR AUTHORIZATION (PA).....	12
WELL-CHILD SERVICES, OR EARLY PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)	12
DEVELOPMENTAL SCREENING TOOLS	14
BEHAVIORAL HEALTH SERVICES.....	14
<i>RBHA Coverage</i>	15
RBHA CRISIS TELEPHONE NUMBERS:.....	15
<i>CMDP Behavioral Health Coverage</i>	16
CRS COUNTY CRISIS LINES	17
<i>Behavioral Health Information and Privacy</i>	17
CHILDREN'S REHABILITATIVE SERVICES	17
PRESCRIPTIONS	18
FAMILY PLANNING.....	19
WOMEN'S CARE.....	20
PREGNANCY/MATERNITY CARE.....	20
MATERNAL HEALTH COORDINATORS	22
SUBSTANCE EXPOSED NEWBORN – SPECIAL CARE.....	23
SUBSTANCE EXPOSED NEWBORN BROCHURE: PAGE 1.....	25
WIC	27
HEAD START.....	27
AZEIP.....	27
<i>URGENT CARE</i>	27
<i>EMERGENCY CARE</i>	28
EMERGENCY TRANSPORTATION.....	28
MEDICALLY NEEDED NON-EMERGENT TRANSPORTATION	28
DENTAL CARE	28
VISION CARE	29
TOBACCO CESSATION	29
SERVICES NOT COVERED OR PAID FOR BY CMDP.....	29
TIPS FOR TRAVELERS	30

OUT-OF-AREA MOVES	30
LEAVING FOSTER CARE	30
DO CAREGIVERS PAY FOR ANYTHING?.....	31
WHAT EVERY MEMBER SHOULD KNOW	31
MEMBER AND CAREGIVER RESPONSIBILITIES	34
SERVICES CAREGIVERS CANNOT AUTHORIZE.....	35
MAINTAINING GOOD HEALTH.....	35
MEMBER CONFIDENTIALITY AND HIPAA NOTICE	35
CMDP MEMBER ADVOCATES.....	36
FRAUD AND ABUSE	36
GRIEVANCES AND APPEALS	37
BEHAVIORAL HEALTH GRIEVANCES	38
CORPORATE COMPLIANCE.....	38
CORPORATE COMPLIANCE HOTLINE	39
Safe Sleep for Babies	40
PRE-TEEN/TEEN VACCINES	41
CATCH-UP IMMUNIZATION SCHEDULE.....	43
FIGURE 2. CATCH-UP IMMUNIZATION SCHEDULE FOR PERSONS AGED 4 MONTHS THROUGH 18 YEARS WHO START LATE OR WHO ARE MORE THAN ONE MONTH BEHIND – UNITED STATES, 2015	43
WHAT IS PERTUSSIS?.....	46
¿QUÉ ES TOSFERINA O PERTUSIS?.....	47

(Revised 6-2015)

CMDP Communications Directory and Instructions

CMDP Mailing Address	DCS/CMDP Site Code 942C P.O. Box 29202 Phoenix, AZ 85038-9202
CMDP Website	www.azdes.gov/cmdp

CMDP TELEPHONE / FAX / EMAIL DIRECTORY

CMDP Telephone Numbers	
Local	(602) 351-2245
Toll Free	1 (800) 201-1795
Grievances	(602) 351-2245
Administration	(602) 351-2245

CMDP service representatives are available to assist you Monday through Friday from 8:00AM to 5:00PM. For more information please visit CMDP on the internet at the web address above.

Fax and Email Information:

Inquiries regarding CMDP Claims, Provider Services, Behavioral Health, Medical Service and Member Services can be faxed, emailed or called in. Fax numbers and email address are listed below:

CMDP FAX Numbers	
Provider/Member Services	(602) 264-3801
Medical Services	(602) 351-8529
Claims	(602) 265-2297
Administration	(602) 235-9146

CMDP Email Contacts	
Claims	CMDPClaimsStatus@azdes.gov
Provider Services	CMDPProviderServices@azdes.gov
Behavioral Health	CMDPBHC@azdes.gov
Medical Services	CMDPNurse@azdes.gov
Member Services	CMDPMemberServices@azdes.gov

Telephone Information:

Telephone inquiries are answered in the order in which they are received. Please listen carefully to the instructions and choose the prompt that best addresses your question(s). Calls may be monitored for training purposes. The following charts will help you to get to the service representative that best fits your needs; however, options may change as CMDP strives to serve you with the best possible service.

LANGUAGE PROMPT SELECTION	
Language	Option
English	Press 1
Spanish	Press 2
Translations Other than Spanish	Press 3

PROMPT SELECTIONS	
Pharmacy Services	Press 5
Providers	Press 2
Member, Caregiver or Case Manager	Press 3
To Speak to an Agent	Dial extension
Operator	Press 0

Once you have selected one of the options from the selection area prompts you will be directed to select one of the following:

PROVIDER MEMBER, CAREGIVER OR CASE MANAGER OPTIONS (after you've pressed option 2 or 3 in Prompt Selections above)	
Eligibility (Includes ID Cards, Member Questions)	Press 1
Claims	Press 2
Dental	Press 3
Medical	Press 4
Behavioral Health	Press 5
Hospital	Press 6
Other	Press 7

INTRODUCTION

WHAT IS CMDP?

The Comprehensive Medical and Dental Program (CMDP) was formed in 1970 and is the health plan for Arizona's children in care. Membership is based on state rule and law. CMDP pays for health care services for children placed in and outside of Arizona and shares the AHCCCS Vision of shaping tomorrow's health care...from today's experience, quality and innovation.

Most CMDP members are eligible for health services covered by the Arizona Health Care Cost Containment System (AHCCCS). AHCCCS is Arizona's Medicaid and KidsCare programs. CMDP becomes the AHCCCS and KidsCare health plan for its members. CMDP provides the same services for all members regardless of AHCCCS eligibility status.

CMDP phone numbers are listed at the top of each page of the handbook. The local phone number is **(602) 351-2245**. For calls from outside of Maricopa County, use the toll free phone number **1-800-201-1795**. The hours of business are 8:00 a.m. to 5:00 p.m., Monday through Friday. CMDP is closed on Saturdays, Sundays and all state holidays.

The CMDP Member Handbook tells how to get health services. The handbook is directed toward caregivers. It is printed in English and in Spanish. If you need it in another language or in another format, please call us.

AMERICAN INDIAN MEMBERS

American Indian members are able to receive health care services from any Indian Health Service provider or tribally owned and/or operated facility at any time.

CULTURAL COMPETENCY

All of us are programmed by our culture. This determines our behaviors and attitudes.

Culture defines:

- How health care information is received
- How rights and protections are exercised
- What is thought of as a problem and how symptoms and concerns about the problem are expressed
- The type of treatment and who should provide it

Culturally Competent Health Care: Health care services should respect the culture of members. Medically necessary covered services are culturally competent when they fit the member. They should be based on the member's needs.

Benefits of Cultural Competency: Most people think their own values and customs are best. They may expect other cultures to share those views. Some benefits of having culturally competent health care services are listed below.

Members and Caregivers:

- Gain sensitivity to member's needs; reduce prejudice and bias
- Improve the quality of member care and outcomes
- Improve member (and caregivers) satisfaction for the services provided

- Develop more appropriate member specific plans of care

CMDP staff and health care providers:

- Work better with diverse patient populations
- Have a better understanding of other cultures in their approach to health care services for children
- Comply with federal and state requirements
- Reduce non-compliance of member (and caregivers) towards services

CMDP wants members to get health care services that are best for them. Please contact Member Services and tell us if any cultural needs are not addressed.

Member Services as a Resource: Use the Member Services Unit as a resource for child-specific, culturally competent health care services and/or providers, such as:

- A specific language or gender, ethnic, geo-graphical or specialized health care provider for the individual needs of a member
- Health care services responsive to a member's cultural or religious beliefs
- Translation services for health care appointments when a language-specific provider is unavailable
- Interpretation services orally or for hearing impaired
- Written health care information in a native language
- Health care information in an alternative format for the visually impaired

LANGUAGE AND ORAL TRANSLATION SERVICES

Contact Member Services if you need CMDP information or materials in another format or language. They are available at no cost to the caregiver or the member. CMDP offers assistance for speaking with CMDP and health care providers in a language other than English. This service does translations for over 200 languages by phone, or in writing upon request. This service is available at no cost to the caregiver or the member. Call Member Services to use this service.

MEMBER SERVICES

Member Services is the main point of contact for calls to CMDP. Member Services helps with questions, concerns or issues about health care services.

Member Services answers questions about:

- Enrollment
- Eligibility
- Member identification cards
- Finding a culturally competent health care provider or a pharmacy

Member Services can be reached by emailing (CMDPMemberServices@azdes.gov) or calling (602) 351-2245 or 1-800-201-1795, Option 3-1. **Call Member Services to report any changes for members, including a PCP and/or PDP change.**

PROVIDER SERVICES

The staff in the Provider Services Unit works with health care providers. They register providers with AHCCCS and CMDP and work to resolve issues concerning providers. Provider Services works with Member Services to share the names and locations of registered providers. Members and caregivers can also contact Provider Services directly to get help in finding health care providers.

ELIGIBILITY AND ENROLLMENT

Children are eligible for CMDP when placed into care. They do not have to be eligible for AHCCCS or the KidsCare program. Agencies that place children in care are:

- Arizona Department of Child Safety (DCS),
- Arizona Department of Juvenile Corrections (ADJC)
- Administrative Office of the Court/Juvenile Probation Office (AOC/JPO)

Children are enrolled with CMDP by the agencies that place them into care. When DCS places a child into care, the caregiver should get the **Notice to Provider, FC-069 form**. This form is part of the child's placement packet. It has the member's CMDP Identification (ID) number and is used as a temporary ID card. **If the member's ID on the Notice to Provider form does not have 9 numbers, add zeros to the front of the numbers until there is a total of 9. For example, the ID number is 123456 (not 9 numbers). Add 000 to the 123456 to get 000123456 (9 numbers). This is the member's CMDP ID number.** Show the form to health care providers and pharmacies, or give them the CMDP ID number. Use the form until the permanent ID card is given to you by the member's Department of Child Safety Specialist (DCSS). If you do not get this form or an ID number, email (CMDPMemberServices@azdes.gov) or call CMDP Member Services (602) 351-2245 or 1-800-201-1795 for help.

DUAL ELIGIBILITY

CMDP members who are eligible for Medicare and Medicaid (AHCCCS) services have dual eligibility. They may be classified as a Qualified Medicare Beneficiary (QMB) or as non-QMB eligible.

QMB-eligible members receive coverage for all Medicaid services including inpatient psychiatric, psychological, respite and chiropractic services.

CMDP members must use health care providers registered with AHCCCS and CMDP. For dual eligible members, Medicare is considered the primary payer and CMDP is the secondary payer. CMDP is responsible for payment of co-insurance or deductibles. (In this instance, please call CMDP Member Services for instructions on submitting these charges for reimbursement.) CMDP covers the cost of pharmacy co-payments.

MEDICARE DRUG COVERAGE FOR BARBITURATES AND BENZODIAZEPINES

CMDP covers drugs which are medically necessary, cost effective, and allowed by federal and state law.

For CMDP recipients with Medicare, CMDP does NOT pay for any drugs paid by Medicare, or for the cost-sharing (co-insurance, deductibles, and co-payments) for these drugs. AHCCCS and its Contractors are prohibited from paying for these drugs or the cost-sharing (coinsurance, deductibles, and co-payments) for drugs available through Medicare Part D, even if the member chooses not to enroll in the Part D plan.

Beginning January 1, 2013, CMDP will no longer pay for barbiturates used to treat epilepsy, cancer or mental health problems, or any benzodiazepines **for members with Medicare**. This is because federal law requires Medicare to begin paying for these drugs starting January 1, 2013.

CMDP will still pay for barbiturates that are **NOT** used to treat epilepsy, cancer, or mental health problems for Medicare members after January 1, 2013.

Some of the common names for benzodiazepines and barbiturates are:

Generic Name	Brand Name
Alprazolam	Xanax
Diazepam	Valium
Lorazepam	Ativan
Clorazepate Dipotassium	Tranxene
Chlordiazepoxide Hydrochloride	Librium
Clonazepam	Klonopin
Oxazepam	Serax
Temazepam	Restoril
Flurazepam	Dalmane
Phenobarbital	Phenobarbital
Mebaral	Mephobarbital

OTHER INSURANCE

CMDP is the payer of last resort for members with other health insurance. CMDP coordinates benefits with the other health insurance plan. Deductibles and co-pays are paid by CMDP. The agencies with custody of CMDP members should give CMDP Member Services written notice of current insurance for the new member. This should be done at the time of enrollment or when it is known.

MEDICAL COVERAGE FOR YOUNG ADULTS IN CARE

Young adults who reach the age of 18 while in out-of-home care may be eligible for the Young Adult Transitional Insurance (YATI) program. The YATI Program is operated by AHCCCS, not CMDP. Contact the Arizona Independent Living Coordinator at 602-771-5886 for help, or contact your local Family Assistance Administration (FAA) Eligibility Office for more information. You can also call Healthearizonaplus (HEAplus) at 1(855) 432-7587.

THE IDENTIFICATION (ID) CARD

The ID card is used to assure providers of payment for covered health care services for current members. Show the ID card to pharmacies and health care providers. It has information for billing CMDP for payment.

A temporary ID card, without the identification of the responsible Regional Behavioral Health Authority (RBHA) information, will be made for each member the day of CMDP enrollment notification, and emailed to the agencies with custody of CMDP members. A permanent ID card will be sent shortly afterwards. This card will contain the name of the behavioral health agency (RBHA, CMDP or CRS) that is responsible for providing behavioral health services.

The CMDP ID card has the phone number of the provider (RBHA, CMDP or CRS) that will give behavioral health or substance abuse services to the member. The member is assigned a RBHA based on the member's court of jurisdiction. The RBHA will pay for most behavioral health services, including most prescriptions for behavioral health conditions. If you have questions or need help in getting behavioral health services, please call the RBHA phone number on the card.

The CMDP ID card is only for the member whose name is on the card. It is unlawful and fraudulent to loan or give this card to anyone else to use. **Do not throw the ID card away.** The card should be kept safe and in the possession of the member and child's caregivers. Please contact Member Services to request a replacement ID card.

When there are problems getting pharmacy services during regular business hours, or non-business hours, call the Member Helpline telephone number as shown on the front of the CMDP ID card 1-800-788-2949. This includes problems such as being turned away at the point of sale.

CMDP has generic ID cards, which are used by shelters, emergency receiving homes and DCS offices. They are only for children that have been recently placed in care and not yet enrolled with CMDP.

To help protect identity and prevent fraud, AHCCCS is adding pictures to its on-line verification tool that providers use to verify member coverage. When the CMDP member has an Arizona driver's license or state-issued identification card, AHCCCS will get their picture from the Arizona Department of Transportation Motor Vehicles Division (MVD). When providers view the AHCCCS eligibility verification screen, they will see the member's picture (if available) with coverage details for that member.

MEMBER INFORMATION

CMDP sends new member packets to the agencies that have custody of members. The materials in the packet are to be given to the new members' caregivers. The materials include the member ID card and health care information, including the selection of a Primary Care Provider (PCP) and a Dental Home Provider (DHP) or a Primary Dental Provider (PDP).

The *CMDP Member Handbook* is revised every year. The member handbook is located on the CMDP website, www.azdes.gov/cmdp.

The *CMDP Provider Directory* is a list of registered health care providers. The list includes PCPs and health care specialists. The directory assists in the selection of a PCP and a PDP. The directory is also located on the CMDP website. Members and caregivers can also contact Member Services to have a copy of the member handbook and the directory mailed to them at no cost. When new placements are identified, member information packets, including member handbooks, are mailed to them.

MEDICAL HOME

Despite the challenges faced by the temporary nature of out-of-home placement and the individual needs between placement types, CMDP continues to strive to establish a true medical home for every child during the period that they are in care. This medical home is one in which care is delivered in accordance with the requirements of EPSDT and in a manner that is accessible, continuous, comprehensive, coordinated, compassionate, and culturally effective.

CMDP's primary care providers (PCPs) play a critical role in establishing the member's medical home and ensuring members receive needed EPSDT screenings and other medically necessary services.

Members along with their caregivers may select the PCP of their choice, but are encouraged to select from CMDP's Preferred Provider Network (PPN) of health care professionals, which includes specialists in all fields, who are currently registered with CMDP and AHCCCS.

Provider Services, Member Services and Medical Services work together to monitor a provider's ability to provide care to members with limited proficiency in English and with special medical, behavioral health, social, and cultural needs.

DENTAL HOME

The American Academy of Pediatric Dentistry (AAPD) and the American Dental Association (ADA) support the concept of a "Dental Home," which is **the ongoing relationship between the dentist who is the Primary Dental Provider (PDP) and the patient, and includes comprehensive oral health care, beginning no later than age one.**

By selecting a PDP, a Dental Home is established. This means that a **child's oral health care is managed in a comprehensive, continuously accessible, coordinated, and family-centered way by a licensed dentist.** The concept of the Dental Home reflects AAPD and ADA policies and best principles for the proper delivery of oral health care to all, with an emphasis on initiating preventive strategies during infancy. An infant oral health exam is simple, easy and effective.

The Dental Home enhances the PDP's ability to provide optimal oral health care, beginning with the age one dental visit for successful preventive care and treatment as part of an overall oral health care foundation for life. Additionally, the establishment of the Dental Home assures appropriate referral to dental specialists when care cannot directly be provided within the Dental Home.

The Dental Home concept allows providers to outreach to members who have not completed visits, as specified in the AHCCCS Dental Periodicity Schedule and allows outreach to those members who have had no-show appointments. The dental home can also assist members in getting referred for additional oral health care concerns requiring additional evaluation and/or treatment.

CHOOSING A PRIMARY CARE PROVIDER (PCP) AND PRIMARY DENTAL PROVIDER (PDP)

CMDP members should have a PCP and a PDP, who act as a personal care doctor and dentist. The PCP and PDP will provide or arrange for the needed health services. Caregivers may want to select a PCP and a PDP that has a focus on children and teens with special health care issues. The PCP and PDP work with specialists, pharmacies, hospitals and other providers to track all care a member receives.

To qualify as a PCP and PDP, a provider must practice in one of the following areas:

- Pediatrics (Medical or Dental)
- Family practice (Medical or Dental)
- General internist
- Certified nurse practitioner
- Physician's assistant and supervised by an physician
- Obstetrics and gynecology (OB-GYN) (for pregnant members)

Reasons to have a PCP and PDP:

- Manages the members medical and dental needs

- Knows the member's medical and dental history
- Will help get the care the member needs and provide coordination of care
- Can help find a specialist when needed by the member
- Will get the member's medical and dental information to those who need it to provide the best care for the member
- Will provide better care for chronic health problems

CMDP has a Preferred Provider Network (PPN) to meet the needs of members. The PPN is made up of PCPs, specialists, PDPs, pharmacies, hospitals and other health care providers. These providers are listed in the *CMDP Provider Directory*. The directory is available by request, at no cost, by calling Member Services. The directory is also on the CMDP web site, www.azdes.gov/cmdp. The list of providers can be searched by ZIP code and type of provider.

Contact Member Services if you need assistance in selecting a PCP and a PDP. **CMDP must know who the PCP and PDP is for each member.** To provide the name of the PCP and PDP, contact Member Services by phone, mail, or e-mail (CMDPMemberServices@azdes.gov).

CHANGING YOUR PCP/PDP

When members move, they may need to change providers. If you change PCP or PDP, request to have member medical records transferred from the old PCP or PDP to the new PCP or PDP. CMDP will work with you to select a new PCP or PDP. To request a change, or to notify CMDP of a change, call Member Services.

SEEING A SPECIALIST

A referral from your PCP or PDP is not needed to see a specialist (except for an orthodontist). Initial evaluations and consultations do not need prior approval (PA), with the exception of chiropractic, podiatry and pediatric developmental/behavioral health assessments. Specialists must get a PA from CMDP before health care services are given. If the services are not approved, a letter is sent stating why and how to appeal that decision. The letter is sent to the agency with custody of the member.

Female members have direct access to preventative care and well care services from obstetrics and gynecology (OB-GYN) providers within the network; they do not need a referral from a primary care provider. Pregnant members may choose their OB-GYN provider as their PCP.

Member Services can give you and the PCP or PDP a list of specialists that are registered with CMDP. They can also be found in the *CMDP Provider Directory*. If you do not have a copy of the directory, call Member Services. The directory is also on the CMDP web site, www.azdes.gov/cmdp.

MEDICAL/DENTAL APPOINTMENTS

Call the PCP and the PDP to make an appointment. The phone number is in the Provider Directory and on the letter from CMDP. When you call, tell them the member is covered by CMDP.

Children must have a full physical exam and a dental visit within the first 30 days of being placed into care. Please schedule a physical exam and a dental visit for members who have not had this exam.

Let DCS or the juvenile justice representative know if the child has any special health care needs. This includes, but is not limited to, pregnancy, chronic asthma and diabetes.

CMDP Medical Services will help locate community support services for the member.

You should be able to get a regular appointment within 21 days of calling a PCP. You should be able to get an urgent (serious, but not life threatening) appointment within two days. You should get an emergency appointment the same day or within 24 hours of your request. Call Member Services if there is a problem getting an appointment.

To cancel or change an appointment with your PCP, PDP, specialist or CRS, call providers at least one day before the appointment. Some providers may attempt to charge a fee for a missed appointment. By State of Arizona law, CMDP cannot pay for missed or no-show appointments.

Ask the PCP which urgent care centers or emergency rooms to use after regular business hours. **Always call the PCP before going to the urgent care or emergency room, unless it is a life-threatening emergency.** You can check the Provider Directory or call Member Services for the approved facilities to use. Tell the PCP and DCS when members get emergency care. It is important for them to know.

COVERED SERVICES

Call Member Services if there are any questions or concerns about covered health care services.

CMDP pays for health care services that are medically needed. The services include, but are not limited to:

- Doctor office visits
- Well-child check-ups/EPSTD/adolescent screenings and treatment
- Immunizations (See the Center for Disease Control and Prevention website for immunization schedules and more information at <http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html>).
- Behavioral health services (see the Behavioral Health Services section)
- Hospital services
- Specialist care, as needed
- Family planning services
- Home and community-based services
- Lab and X-ray services
- Pregnancy care
- 24-hour emergency medical care
- Dental care, including preventative care
- Emergency transportation
- Vision care and eyeglasses
- Medically-needed transportation
- Pharmacy services, medical supplies and equipment
- Transplants (CMDP will only pay for transplants listed as covered by AHCCCS)
- Dental Care – Preventative, diagnostic and restorative

INCONTINENT BRIEFS

Incontinent briefs (diapers), including Pull-Ups and/or Incontinence Pads, may be provided by CMDP if the child needs diapers to:

- Prevent skin breakdown

- Participate in social, community, therapeutic and educational activities

These are the CMDP guidelines for incontinent briefs (diapers):

- The child must be older than 3 years of age.
- The child has a documented medical condition that is causing them to have problems with bladder and/or bowel control.
- The child needs the incontinent briefs to prevent skin breakdown and to enable participation in social community, therapeutic, and educational activities under limited circumstances.
- The PCP has written a prescription for up to 240 diapers per month, unless more are needed depending on the medical condition.
- If DCS is currently providing a stipend toward the purchase of the diapers and CMDP is going to supply them, the DCSS must discontinue the stipend and cannot give the family a future stipend.
- CMDP will have the diapers delivered to the home by a designated supply company.

For questions about diaper requests, please contact Medical Services at (602) 351-2245 or 1-800-201-1795, Option 3-4.

PRIOR AUTHORIZATION (PA)

Some services may need approval from CMDP before being provided. It is up to the health care provider to get a Prior Authorization (PA) from CMDP. This will let a provider know what services CMDP will cover. This information is posted on our website as well.

The response to the PA request is based on a member's medical needs. A second opinion may be needed. More tests may also be needed before services are approved, if in the best interest of the member. It is up to the health care provider know what services will need a PA or not. Each request is reviewed by a CMDP nurse.

CMDP may send out a Notice of Extension letter to get more information from a provider. This can help us make a decision in the best interest of the member. This can lead to the decision not being made for another 14 days. If CMDP does not get the new information, the PA request can be denied or delayed. If the request is denied, a Notice of Action letter is sent to the member's DCSS or legal guardian.

If there are questions on how CMDP made a decision, please contact Medical Services at (602) 351-2245 or 1-800-201-1975, Option 3-4. CMDP can also give the member's DCSS or legal guardian information about the criteria that a prior authorization decision was based on.

Emergency services do not need a PA from CMDP.

WELL-CHILD SERVICES, OR EARLY PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

Early Periodic Screening, Diagnostic and Treatment (EPSDT) is 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. It also includes correction, and improvement 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. This service can also assist Medicaid members in using 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 improve 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 the same as an EPSDT visit and includes all screenings and services described in the AHCCCS EPSDT and dental periodicity schedules. EPSDT screening exams include:

- Unclothed physical exam
- Nutritional assessment
- Developmental and growth assessment
- Behavioral health assessment
- Blood lead screening/test

Well visits (well exams) such as, but not limited to, well woman exams, breast exams and prostate exams are covered for members 21 years of age and older. Most well visits (also called checkup or physical) include a medical history, physical exam, health counseling and medically necessary immunizations. (See EPSDT for well exams for members under 21 years of age)

You should call the member's PCP and ask to make an appointment for an EPSDT/well child visit.

Amount, Duration and Scope: The Medicaid Act defines EPSDT services to include screening services, vision services, dental services, hearing services and "such other necessary health care, diagnostic services, treatment and other measures described in federal law subsection 42 USC 1396d(a) to correct or improve 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 improve physical and mental defects, conditions, and illnesses discovered by the screening process when those services fall within one of the 28 optional and mandatory categories of "medical assistance" as defined in the Medicaid Act. Services covered under EPSDT include all 28 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.

There are ten required EPSDT visits by the age of 2 years. The intervals are ages 2 to 4 days, and 1, 2, 4, 6, 9, 12, 15, 18 and 24 months.

After age two, children and youth require annual EPSDT visits until the 21st birthday. See the EPSDT Periodicity Schedule in this handbook for more details.

DEVELOPMENTAL SCREENING TOOLS

It is important for the PCP to use the Developmental Screening Tool during an EPSDT exam. Your PCP can choose one of three different tools: Parents' Evaluation of Developmental Status (PEDS Tool), Modified Checklist for Autism in Toddlers (M-CHAT), or the Ages and Stages Questionnaire (ASQ). The PEDS Tool is used for children (newborn up to age 8) who are at risk of or identified as having developmental delays. The M-CHAT is used for children between 16 and 30 months of age, and can help identify children who need further screening for Autism Spectrum Disorder. Lastly, the ASQ helps identify developmental and social-emotional delays in children ages birth to six. Children in care are often at risk for behavioral and developmental issues. Early services for these children help to ensure that they start school with the highest potential for learning. Foster caregivers should ensure that a developmental screening is done at each EPSDT well-child visit. Only a provider who is certified by AHCCCS in the use of the PEDS Tool, M-CHAT, and ASQ can complete these screenings. Therefore, it is important to find a provider who is certified in these developmental screening tools.

If there are questions about EPSDT or well-child services, please call Medical Services, (602) 351-2245 or 1-800-201-1795, Option 3-4. Questions about locating PEDS, M-CHAT, or ASQ certified providers should be directed to Member Services, Option 3-1.

BEHAVIORAL HEALTH SERVICES

Behavioral health issues are the most common health problems reported in children in care. If these issues are not addressed, problems may arise in placements. Also, they may result in long term behavior problems. Members receive their behavioral health coverage through a Regional Behavioral Health Authority (RBHA), CMDP, and Children's Rehabilitative Services (CRS).

Behavioral health services include, but are not limited to:

- Behavior management (behavioral health personal assistance, family support, home care training, self-help, peer support)
- Behavioral health case management services (limited)
- Behavioral health nursing services
- Behavioral Health Residential Facilities/BHRFs (Previously called Therapeutic Group Homes/TGHs)
- Behavior health therapeutic home care services/HCTCs (sometimes called therapeutic foster care)
- Emergency behavioral health care
- Emergency and non-emergency transportation
- Evaluation and assessment
- Individual, group, and family therapy and counseling
- Inpatient hospital services
- Non-hospital inpatient psychiatric facilities (Behavioral Health Inpatient Facilities/BHIFs (Previously called Residential Treatment Centers/RTCS)
- Laboratory and radiology services for psychotropic medication regulation and diagnosis
- Opioid agonist treatment

- Partial care (supervised day program, therapeutic day program, and medical day program)
- Psychosocial rehabilitation (living skills training, health promotion, supportive employment services)
- Psychotropic medication
- Psychotropic medication adjustment and monitoring
- Respite care
- Rural substance abuse transitional agency services
- Behavioral Health Screening

A PCP can help members that have depression, anxiety, and attention deficit-hyperactivity disorders. The services the PCP can give are prescriptions and medication monitoring visits. A behavioral health referral is always recommended and is especially important for youth under six years of age. It is best practice to have a Behavioral Health Medical Professional, such as a psychiatrist, assess, evaluate, and monitor the unique behavioral health needs of children in care.

RBHA Coverage

Most AHCCCS and KidsCare eligible CMDP members get behavioral health services, which include drug and alcohol abuse services, from the Arizona Department of Health Services Regional Behavioral Health Authority (ADHS-RBHA). New members are assigned to a RBHA when enrolled with CMDP or another AHCCCS health plan. The assignment of a RBHA for all members is based on each member’s court of jurisdiction.

The following is a list of the RBHAs:

Mercy Maricopa1-800-564-5465

Counties served: Maricopa

Cenpatico Integrated Care.....1-866-495-6738

Counties served: Pinal,
La Paz, Yuma, Cochise,
Greenlee, Graham, Santa Cruz, Pima

Health Choice Integrated Care.....1-800-640-2123

Counties served: Mohave, Gila
Coconino, Apache, Navajo, Yavapai

In the event of a crisis, call the Crisis Line for the RBHA in your area. If it is a life-threatening emergency, dial **9-1-1**.

RBHA CRISIS TELEPHONE NUMBERS:

Mercy Maricopa1-800-631-1314

Cenpatico Integrated Care.....1-866-495-6735

Health Choice Integrated Care...1-877-756-4090

All members should go to the RBHA for an initial evaluation. For CMDP members there is a special RBHA Urgent Response. Most CMDP members will be evaluated by the RBHA at the time of entry to

out-of-home care. CMDP covers the ride to the first RBHA evaluation, if the caregiver, DCS or juvenile justice representative cannot provide it.

The CMDP ID card has the phone number of the RBHA that will give behavioral health and substance abuse services to the member. Services are assigned to a provider based on where you live. If you have questions or need help getting behavioral health services, please call the number on your card. The RBHA will pay for most behavioral health services including prescriptions for behavioral health conditions. If you have questions or need help in getting behavioral health services, please call the phone number on your card.

Please do not use the CMDP ID card to pay for RBHA medications. CMDP does not cover this service. The RBHA is responsible for payment. Ask the RBHA doctor which pharmacy to use, and give the member's RBHA ID number to the pharmacist.

CMDP Behavioral Health Coverage

Children that are not AHCCCS (Non-Title XIX) or KidsCare (Non-Title XXI) eligible receive their behavioral health services through CMDP and DCS regional contracts. CMDP covers inpatient psychiatric hospitalization, outpatient psychiatric evaluation, and medication management. There must be a prior authorization (PA) from CMDP before services can start. DCS regional contracts provide all other behavioral health services. Members should contact the DCS Behavioral Health Clinical Coordinator in their region to request these services.

A PCP can help members that have mild depression, anxiety, and attention deficit-hyperactivity disorders. The services the PCP can give are prescriptions and medication monitoring visits. A RBHA referral is always recommended and is especially important for youth under six years of age. It is best practice to have the child's RBHA provider assess, evaluate, and monitor the unique behavioral health needs of children in care.

For assistance, contact the CMDP Behavioral Health Coordinator at (602) 351-2245 or 1-800-201-1795, Option 3-2.

Children's Rehabilitative Service (CRS) Behavioral Health Coverage

CRS provides behavioral health services for members enrolled with CRS due to a qualifying condition. Please refer to Children's Rehabilitative Services section on page 10 to learn more about eligibility. Members enrolled with CRS will receive their behavioral health coverage with CRS no matter where they live.

The CMDP ID card has CRS' phone number. CRS will pay for most behavioral health services including prescriptions for behavioral health conditions. If you have questions or need help in getting behavioral health services, please call the phone number on your card.

Please do not use the CMDP ID card to pay for CRS covered medications. CMDP does not cover this service. CRS is responsible for payment. Ask the CRS doctor which pharmacy to use, and give the member's CRS ID number to the pharmacist. You can call CRS Member Services at 1(800) 348-4058.

In the event of a crisis, call the please call the RBHA Crisis Line. If it is a life-threatening emergency, dial **9-1-1**.

CRS COUNTY CRISIS LINES

Counties Served	Phone
Cochise, Gila, Graham, Greenlee, La Paz, Pinal, Santa Cruz and Yuma Counties	1-866-495-6735
Pima County	1-800-796-6762
Maricopa County	1-800-631-1314
Apache, Coconino, Mohave, Navajo, and Yavapai Counties	1-877-756-4090

Behavioral Health Information and Privacy

There are laws about who can see your behavioral health information with or without your permission. Substance abuse treatment and communicable disease information (for example, HIV/AIDS information) cannot be shared with others without your written permission.

At times your permission is not needed to share your behavioral health information to help arrange and pay for your care. These times could include the sharing of information with:

- Physicians and other agencies providing health, social, or welfare services;
- Your medical primary care provider;
- Certain state agencies involved in your care and treatment, as needed; and
- Members of the clinical team² involved in your care.

At other times, it may be helpful to share your behavioral health information with other agencies, such as schools. Your written permission may be required before your information is shared.”

CHILDREN’S REHABILITATIVE SERVICES

CRS provides screening, evaluation, medical treatment and rehabilitation for members under the age of 21 with qualifying chronic and disabling conditions. Members must also be AHCCCS (Title XIX) eligible to receive services from CRS.

Some of these conditions include, but not limited to:

- Spina bifida
- Congenital heart defects
- Cerebral palsy
- Certain birth defects, cleft lip and/or palate

When a member with a possible CRS condition is known, CMDP will complete the CRS application with the DCS worker. Evaluation and treatment for a member’s CRS condition will be provided by CRS. The member will continue to receive all other health care services through CMDP.

The member may be assigned to a Multi-Specialty Interdisciplinary Clinic (MSIC). MSICs are facilities or provider groups where doctors and other providers meet with CRS members and caregivers. This helps doctors, providers and caregivers/members work together to coordinate the members' care all at one location and sometimes at the same appointment.

The services offered by MSIC include primary care, specialty and behavioral health services. CMDP may discuss assigning the member to one of these clinics to better meet their health care needs.

The MSICs and the services they offer:

Metro Phoenix Region

DMG Children's Rehabilitative Services

- CRS specialty care
- New primary care services
- Expanded behavioral health services

Southern Region

Children's Clinics for Rehabilitative Services

- CRS specialty care
- Primary care services
- Expanded behavioral health services

Northern Region

Children's Rehabilitative Services at Flagstaff Regional Medical Center

- CRS specialty care

Southwestern Region

Tuscany Medical Plaza

Yuma CRS Clinic

- CRS specialty care

To make, change or cancel the member's appointments contact the CRS clinic or provider.

Members who have a private primary insurance are not required to use CRS for their health care services. Members who do not have a private primary insurance and decide not to enroll and receive CRS covered services may be billed by the provider who renders an unauthorized CRS covered service. CMDP will only be responsible for any deductibles and copayments.

For assistance, contact the CMDP Medical Care Coordinator at (602) 351-2245 or 1-800-201-1795, Option 3-4.

PRESCRIPTIONS

When a CMDP provider writes a prescription, it should be filled at a pharmacy that is both registered with AHCCCS and in the CMDP Pharmacy Network. Over-the-counter medications are covered by CMDP when "medically necessary" (it will help the member get better). A prescription from the PCP is needed. Use the CMDP ID card or the Notice to Provider form for payment.

The major food and retail stores in our program are listed in the *CMDP Provider Directory*. Most of the pharmacies in Arizona are in the directory. For help finding a pharmacy, call Member Services.

You can also go to the CMDP website to view the directory. If you have questions or problems getting pharmacy services during business hours or non-business hours, call the Member Helpline telephone number shown on the front of the CMDP ID card.

CMDP has a Preferred Drug List (PDL). The PDL, or formulary, is a list of drugs approved by CMDP. Health care providers should refer to the PDL when prescribing drugs. For drugs not on the PDL, your provider will need a PA from CMDP *before* you go to the pharmacy.

Not all of the drugs on the PDL are shown. If you are not able to find your drugs on the list please remember:

- Most generic drugs are approved by CMDP.
- CMDP covers all drugs when your health care provider tells us that it is *medically necessary* (it will make a member better) and a PA is obtained.
- Prescriptions written by RBHA providers should be filled *using the RBHA ID number*, not the CMDP ID card.
- Infant formulas and diapers are not covered through the PDL/pharmacy.

The PDL is updated as often as needed to make important changes. The PDL can be viewed on the CMDP website at www.azdes.gov/cmdp.

If the member is CRS eligible and needing to fill a CRS medication, questions regarding fills can be answered through the CRS pharmacy help line at 1-800-310-6826. Please have the member's CRS ID# number available. The pharmacy may ask you for the following information:

-RX BIN#61094
-GRP#ACUAZ
-RX PCN #9999

FAMILY PLANNING

Family Planning services are for all members age 12 and older. CMDP sends a Family Planning letter to the home of these members. CMDP asks members to talk with their doctors about Family Planning. This is so that good choices can be made. Family Planning services are free to CMDP members. Family Planning includes, but is not limited to:

- Education on how to prevent a pregnancy
- Medications
- Supplies (including, but not limited to, diaphragms, condoms, foams, patches, and implanted birth control methods)
- Annual physical exams
- Lab tests
- Radiological exams related to family planning
- Treatment of problems caused by the use of contraceptives
- Emergency oral contraception within 72 hours after unprotected sex

CMDP members should see their doctor if they are sexually active. Their doctor will give them yearly exams. They will also do lab tests. Female members can see a gynecology provider. No referral is needed.

CMDP providers teach members about sexually transmitted diseases (STDs). They teach the members how STDs are passed on to others. The providers teach members how to prevent STDs. CMDP covers tests for STDs. CMDP also covers the test for HIV (the virus that causes AIDS). If testing is needed, the CMDP member must receive HIV testing counseling from the local health department. They can also get this counseling from another health related provider.

Members 13 years of age and older can consent when a doctor states HIV testing is necessary. No other approval is needed. Members less than 13 years old must have approval. This approval can come from their Department of Child Safety Specialist. It can also come from a juvenile justice representative. Talk with them if HIV testing is needed.

Female members wanting birth control should talk to their doctor. They should have a physical exam. They should also have lab tests. After that exams and lab tests should be done on a regular basis.

The following are **not covered** for the purpose of family planning:

- Infertility services
- Pregnancy termination counseling
- Pregnancy termination
- Sterilization
- Hysterectomies

WOMEN'S CARE

Female members have direct access to preventative and well care services from a gynecologist within the CMDP network without a referral from a primary care provider. The provider must be in the CMDP network. It is very important for sexually active or age-appropriate female members to get a well-woman exam. They should get the exam at least once a year. This will let the doctor monitor their health. It will also assist them to stay healthy. Preventive services include, but are not limited to:

- PAP smear
- Breast exam
- Mammogram – when medically required
- Vaccinations- including HPV vaccine
- Screening for sexually transmitted infections

Human papillomavirus (HPV) is a common virus. It can cause cancer of the cervix. The virus is spread through sexual contact. Often HPV has no symptoms. This makes it hard for someone to know they have it. It is important that both females and males get the HPV vaccine. They should get the vaccine before they are sexually active. This is when the vaccine can give the most protection.

PREGNANCY/MATERNITY CARE

Maternity Care Service Definitions

Maternity care includes medically needed services related to all aspects of pregnancy. This may include but is not limited to pregnancy identification, prenatal care, labor and delivery services, and postpartum care. Other services include medically needed preconception (before pregnancy) counseling.

Maternity care coordination includes maternity care related activities that help consider all aspects of pregnancy. This may include identification of care needs through risk assessment and evaluation;

development of a care plan to address care needs, and monitoring the care plan to make sure all services appropriately addressed.

Practitioner refers to certified nurse practitioners in midwifery, physician's assistants and other nurse practitioners.

Postpartum care refers to the health care provided up to 60 days after delivery. Family planning services are included during this time, if provided by the physician or practitioner.

Preconception counseling is provided as part of the annual well woman visit when medically necessary. This counseling focuses on the early detection and management of risk factors before pregnancy, and includes efforts to influence behaviors that can affect a fetus (even before conception is confirmed), as well as regular health care. The purpose of preconception counseling is to ensure that a woman is healthy prior to pregnancy. Preconception counseling does not include genetic counseling.

Prenatal care refers to the health care provided during pregnancy and includes: early and ongoing risk assessment; health education; and medical monitoring, intervention and follow-up.

High risk pregnancy is when you have health problems like asthma, high blood pressure, diabetes, depression or HIV.

You may have had problems with a previous pregnancy. If you have a high-risk pregnancy, you may need to see your Obstetrical (OB) doctor more often during pregnancy.

Low birth weight infant is a baby weighing 5 lbs., 8 oz. or less at birth. Women who have a history of low birth weight babies should contact their OB doctor as soon as they find out that they are pregnant.

Early prenatal care is very important. Early care may decrease your risk of having another low birth weight baby.

OB case manager is a nurse or social worker who assists pregnant members with their health needs before, during and after pregnancy. The OB case manager may also help with referrals to community agencies such as WIC, behavioral health and Healthy Families.

Obstetrician is a doctor who takes care of women while they are pregnant, during delivery and after the baby is born.

Maternal fetal medicine doctor is a specialist in treating pregnant women who have high-risk medical conditions during their pregnancy.

Nurse midwife is a specially trained nurse that can provide OB care, support and education to women during their pregnancy, labor, delivery and after delivery.

Licensed midwife is a state licensed person that can provide OB care, support and education to healthy women who have no health risks. The licensed midwife provides this service during pregnancy, labor and childbirth and after baby is born.

CMDP does not recommend the use of midwife providers, as we consider our members "at risk" and recommend they be seen by a certified nurse practitioner, or OB/GYN.

Maternal Health Coordinators

CMDP Maternal Health Coordinators (MHC) will assure that all needed services are provided to pregnant members. For assistance, call Medical Services at (602) 351-2245 or 1-800-201-1795, Option 3-4, and ask to speak to the Maternal Health Coordinator.

If a member thinks she is pregnant, make an appointment with the PCP at once. The PCP can prove that the member is pregnant. The PCP will provide the names of Primary Care Obstetricians (PCOs) for the member to choose from. A member can also call Member Services for help in choosing a PCO. If the member is new to care and has been receiving care from a PCO, to ensure continuity of care the member can continue to see the PCO. If the PCO is not registered with CMDP, efforts will be made to register this provider.

CMDP pays for obstetric (OB) services. The PCO specializes in OB care. The PCO monitors and treats pregnant women during pregnancy. The services include delivery and post-partum or after-delivery care. Members should remain with the same PCO for the entire pregnancy. However, if a member moves or has to change her PCO, as is her right, every effort is made to ensure there is communication between the PCOs so there is no interruption in care.

The PCO starts the member on regular checkups. The check-ups are to make sure the pregnancy is going well. Early health care and regular checkups during pregnancy are important to the health of the mother and child.

The standards regarding appointment times for all pregnant members to see their PCO:

- First Trimester (the first 3 months of pregnancy), within 14 days of request
- Second Trimester (the second 3 months of pregnancy), within 7 days of request
- Third Trimester (the last 3 months of pregnancy), within 3 days of request
- High Risk (having special needs that put the mother or the baby at risk of harm), within 3 days of request
- Emergency (when a member has to be seen immediately because of a crisis situation, like bleeding, etc.), immediately.

If you have any problems getting an appointment within these timeframes, please contact Member Services at (602) 351-2245 or 1-800-201-1795, Option 3-1.

The PCO should tell the MHC if there are any special health care needs. The PCO can also ask for a listing of CMDP registered specialists. It is important for the member to keep all appointments scheduled by the PCO.

The MHC contacts the Department of Child Safety Specialist (DCSS) and/or caregiver to ensure the member is getting prenatal care. The MHC also ensures the member gets the appropriate testing. This includes testing for HIV. The MHC will follow up with the DCSS to arrange for counseling, as needed.

CMDP covers pregnancy termination (including Mifepristone [Mifeprex or RU-486]) in one of the following situations:

- a) The pregnant member suffers from a physical disorder, physical injury, or a 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.

- b) The pregnancy is the result of rape or incest.
- c) The pregnancy is a result of rape.
- d) The pregnancy termination is medically necessary according to the medical judgment of a licensed physician, who attests that continuation of the pregnancy could be reasonably be expected to pose a serious physical or behavioral health problem for the pregnant member by:
 - i. Creating a serious physical or behavioral health problem for the pregnant member
 - ii. Seriously impairing a bodily function of the pregnant member
 - iii. Causing dysfunction of a bodily organ or part of the pregnant member
 - iv. Exacerbating a health problem of the pregnant member, or
 - v. Preventing the pregnant member from obtaining treatment for a health problem.
- e) If the pregnancy is the result of rape or incest it must be reported to the police. CMDP must be notified and given a copy of the police report. The report must have the name of the agency to which it was reported, and the date the report was filed. The agency with custody of the member knows the procedures to follow.

Authorization from the member, legal representative, a court order **and** CMDP approval are needed, **unless it is an emergency.**

Substance Exposed Newborn – Special Care

Many children who come to the attention of DCS are identified as having substance-exposure at birth and are considered “Substance-Exposed Newborns” or SEN’s. Substances identified by hospitals and other medical professionals can include exposure to alcohol, amphetamines, cocaine, inhalants, marijuana, heroin and other drugs of abuse. Being aware of the signs of a substance exposed newborn is very important for those caring for these vulnerable infants and children.

What to expect when caring for Substance Exposed Newborn (SEN):

Not all infants/children exposed to drugs will have problems. There are several myths associated with Substance Exposed Newborns. The labels of “ice babies” or “meth babies” are inaccurate due to lack of scientific evidence to support these labels.

The effects of drugs on infants/children will depend upon the amount of drug used and how long the drug was used during the pregnancy. The drug exposed infant may be at risk for problems later in life, such as speech delay, attention deficit hyperactivity disorder and behavioral problems that may not be clinically present until the child is over age two or even school age.

Some of the symptoms that drug-exposed infants and children have are not exclusive to drug exposed infants/children and may be observed when there has not been exposure. A detailed history of drug/alcohol used during pregnancy, in addition to stressors and environmental effects is the key to the diagnosis.

Common Symptoms and Suggested Care Plans:

The care plan for the infant/child should be made with the child’s pediatrician to ensure appropriate medical needs are met. Care and/or treatment is based on the symptoms the infant/child may be showing, not on the fact that the child is drug exposed.

Consistent routine is extremely important, especially if child is going on visitations with parents. Caregivers need to be aware that best way to interact with infant/child to decrease the infant/child's reaction. The infant/child's reaction may not be due to rejection or poor attachment but rather a coping response to loss and grief.

Substance Exposed Newborn Brochure: Page 1

You can also view the brochure at the following web link:

<https://www.azdes.gov/InternetFiles/Pamphlets/pdf/CSO-1072A.pdf>



CM **DIP** **COMPREHENSIVE MEDICAL & DENTAL PROGRAM**

ARIZONA DEPARTMENT OF CHILD SAFETY

Developmental Interventions

- Ask the baby's Pediatrician for a referral to the Arizona Early Intervention Program (AzEIP) for infants/toddlers 0-3 years of age
- Enroll the toddler in an Early Head Start or Head Start program
- Read to and interact verbally on a daily basis with the baby
- Ask the baby's Pediatrician to consider a speech referral – if early vocalizations are not present or the infant has a speech delay
- Ask the baby's Pediatrician to consider a hearing evaluation if the infant does not appear to hear or respond to your voice. All infants should be screened for hearing loss at birth.

Handle with Care

Special Care for the Substance Exposed Newborn



Equal Opportunity Employer/Program - Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1. • Free language assistance for department services is available upon request. CSO-1072A (3-15)

P.O. BOX 29202
PHOENIX, ARIZONA 85038-9202
Phone: (602) 351-2245
Toll Free: 1-800-201-1795
Fax: (602) 351-8529 (Medical Services)

Substance Exposed Newborn Brochure Page 2

You can also view the brochure at the following web link: <https://www.azdes.gov/InternetFiles/Pamphlets/pdf/CSO-1072A.pdf>

Other helpful web links:
www.healtharizonaplus.gov
www.azlinks.gov

SIDS Prevention:

- The American Academy of Pediatrics *Back to Sleep Program* states: always have infants sleep on their back, unless they are watched at tummy time
- Avoid overheating: dress the infant properly. Do not over bundle, but keep the baby in the right clothing & blankets for the right warmth
- Keep the baby away from cigarette smoke exposure
- Keep the baby off of soft surfaces, pillows, blankets, crib bumpers, mattresses. This increases the risk of Sudden Infant Death Syndrome (SIDS)

Comfort Measures

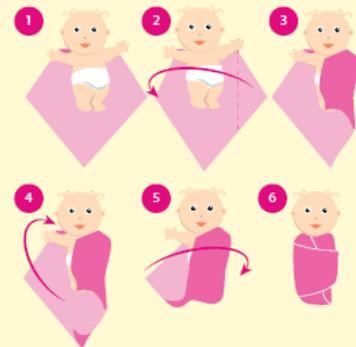
- Handle the baby gently.
- Allow the baby to rest in between feeds and diaper changes
- Don't over stimulate or handle the baby too much
- Avoid over stimulation by siblings and family members
- Establish a sleep & wake routine. This will help keep the baby calm
- Keep a consistent & stable environment
- Coordinate all care (diaper changes, feedings, etc.) after the infant wakes
- Encourage the baby to self soothe by sucking on a pacifier or baby's fingers or hand
- Keep the baby swaddled in a light weight blanket for comfort

Irritability and Sleeping Difficulties:

- Don't allow the baby to become too excited
- Keep the room dark and calm, without loud noises or bright lights
- Swaddle the baby in a flexed (bent slightly at waist & knees) position
- Vertical rocking with an up & down motion is more calming than horizontal – side-to-side rocking
- Allow the baby to look away, if eye contact is too much
- Eyeglasses, large earrings and full hair may over stimulate the baby
- Some babies may be more happy being held at arm's length

Feeding

- Give the baby small, regular feeds
- You may need to try different nipples, if the baby doesn't feed well
- Offer a pacifier to satisfy the baby's sucking reflex. Not all sucking means hunger
- Discuss the best calorie needs with the baby's Pediatrician
- You may need to wake infant every 3-4 hours, if they are not gaining enough weight
- Breast milk is best. The mother must not use drugs that are not prescribed by a healthcare provider, though.
- Ask the baby's Pediatrician if you need a referral for feeding evaluation



Muscle Tone and Posture

- Do gentle movement of the arms and legs
- A gentle massage may help the baby relax
- Be sure to use supportive positioning for baby. Keep in secure setting without a great deal of excessive movement
- Be sure the baby spends time on their tummy during the daytime. You must watch the baby when in this position, as the substance-exposed baby is at greater risk of SIDS. Tummy time helps the baby develop good head support, trunk support, and explore their environment. In addition, it avoids flattening of their head
- No walkers. Walkers are not only dangerous, but they position infants/toddlers in unnatural postures. These unnatural positions may delay normal development
- Ask your Pediatrician if the baby may need an Occupational (OT) or Physical Therapy (PT) evaluation for delays in movement

COMMUNITY SERVICES

WIC

The special Supplemental Nutrition Program for Women, Infants and Children (WIC) serves to safeguard the health of low-income women, infants and children up to the age of 5 who are at risk nutritionally. WIC can give a family many services WIC provides nutritious foods to supplement diets. They also give information on healthy eating and referrals for health care. WIC provides services to pregnant, breastfeeding or post-partum women. Coverage for the mother lasts for 6 months after pregnancy if not breastfeeding. They cover for 1 year if breastfeeding. The website address for more WIC information is www.azdhs.gov/azwic. The toll-free Arizona number is **1-800-252-5942**.

If CMDP members lose their eligibility, they can contact the above phone number for referrals to low cost services.

Head Start

Head Start and Early Head Start are child development programs that serve children from birth to age 5, pregnant women and their families. They have the overall goal of increasing school readiness of young children who are in low-income families. The website address for more Head Start information is www.azheadstart.org. The phone number is **1-866-763-6481**.

AzEIP

The Arizona Early Intervention Program (AzEIP) is a statewide system of programs and services. AzEIP is designed to provide support for families of infants and toddlers, newborn to 3 years old, with disabilities or delays. The goal is to help these children reach their full potential. A newborn to 3-year-old child who is the victim of abuse or neglect can get an AzEIP evaluation. The web site address for AzEIP is www.azdes.gov/azeip/. The phone number for the Phoenix area is **602-532-9960**, and toll free **1-888-439-5609** for all other areas of the state.

Additional resources for treating obesity and nutritional information include:

- (NUPAO) <http://www.azdhs.gov/phs/bnp/nupao/>
- (ADHS) <http://www.eatwellbewell.org/>

You can also contact CMDP Member Services to learn more and for help getting services from any of these programs.

URGENT CARE

Call your PCP to get advice after normal business hours, at night or on weekends. You may be told to come to the office in the morning or to go to a hospital right away. If you cannot reach the PCP, go to an **urgent care center** if the member's life is not in danger. (*See emergency care definitions.*) To access afterhours/urgent care contact information, you can check the Provider Directory or call Member Services (602-264-3801 or toll free 1(800)201-1795).

Urgent care centers can be used for a cough, sprain, high fever or earache. Urgent care centers have many of the same services as a doctor's office. They can also call **9-1-1** to take a child to the hospital if needed.

Tell the PCP and the DCSS when members receive urgent care. This is important for them to know.

EMERGENCY CARE

Emergencies are medical problems that may be life threatening if not treated quickly. Examples of emergencies are major bleeding, broken bones, breathing difficulties, seizures, and unconsciousness.

In a true medical emergency, the well-being of the member is most important. Please dial **9-1-1** or go to the nearest hospital emergency room (members have the right to obtain emergency services at any hospital or other emergency room facility). Show the CMDP ID card to pay for any services. Emergency services do not need a PA from CMDP.

A hospital emergency room is not to take the place of a doctor's office. Do not use it for minor medical problems.

Tell the PCP and the DCSS when members receive emergency care. This is important for them to know.

EMERGENCY TRANSPORTATION

Dial **9-1-1** or contact the local ambulance service for transportation in a life-threatening emergency situation. This service is covered by CMDP.

MEDICALLY NEEDED NON-EMERGENT TRANSPORTATION

Caregivers should arrange their own transportation to and from medical appointments. This includes your own car, taking the bus, having a family member or friends give you a ride. If unsuccessful in arranging transportation, contact your DCSS. They will help you arrange transportation. (It is recommended this process start no later than 4 days prior to the appointment.) If unable to reach your DCSS, contact Member Services at (602) 351-2245 or 1-800-201-1795 for assistance arranging transportation. Arrangements for non-emergent transportation must be made at least 24 hours in advance of the appointment.

DENTAL CARE

The first set of teeth, (often called “baby teeth”), are important and should be cared for. The teeth begin to appear in a child’s mouth at about 6 months of age. The baby teeth not only help your baby chew and later speak, but they help save room for the permanent teeth.

Tooth decay can occur in the baby teeth so it is important to start dental care at an early age. This includes having your PDP apply fluoride varnish. Fluoride varnish can help protect baby teeth from tooth decay before seeing a dentist. PCPs can apply this to members who are at least 6 months of age, with at least one tooth eruption. Additional applications can occur every 6 months during an EPSDT visit until the members second birthday. The American Dental Association recommends that you **bring your baby to the dentist at one year of age. This early visit to the dental office is known as a “well-baby checkup” and establishes a Dental Home for future care** (see the Dental Home Section of this handbook).

CMDP members should start dental services at age one! Regular dental checkups should occur every 6 months following the first visit. These allow the dentist to look for decay and begin any necessary treatment as soon as possible. Checkups include dental cleaning and fluoride treatment to help ensure the long-term health of the child’s teeth and gums.

An oral health screening should be part of an EPSDT screening done by a PCP and see your PDP regularly. It does not take the place of an exam through a direct referral to a dentist. Members do not

need a referral from their PCP and can see any dentist listed in the Provider Directory. Call the dentist you select to schedule a visit. If help is needed to find a dentist, contact CMDP. To cancel or change an appointment with your PDP, call the provider at least one day before the appointment. Some providers may attempt to charge a fee for a missed appointment. By State of Arizona law, CMDP cannot pay for missed or no-show appointments.

Routine dental services are covered by CMDP without a PA or Predetermination. **A dentist needs approval in advance (PA or Predetermination) 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
- Fluoride varnish applied by a PCP or PDP
- Dental education

VISION CARE

Vision care services include:

- Eye exams
- Eyeglasses and bifocals
- Scratch coating
- Repairs and replacement of eyeglasses
- Tinted lenses (when medically needed)
- Contact lenses (with a statement of why they are medically needed)

TOBACCO CESSATION

CMDP will help members who want to stop using tobacco. There are products that can help this. CMDP will pay for these products if the doctor writes a prescription. Members can see their doctor to get this. This includes over-the-counter products. This includes products like Nicotine replacement treatment. Young adults, 18 and older, may contact Arizona's Smoker's Helpline (ASH). This is a free phone service. They can also be contacted on the web. This service helps people to quit smoking. ASH can be called at **1-800-556-6222**. They can also be reached at **www.ashline.org**.

SERVICES NOT COVERED OR PAID FOR BY CMDP

Listed below are general guidelines of services CMDP **does not cover**:

- Any care that is not medically needed
- Any hospital admission, service or item that needed prior authorization (PA) but was not approved in advance or was denied
- Services or items for cosmetic purposes; services needed for the psychological well-being of the member need a PA
- Services or items that are free of charge or for which charges are not usually made

- Pregnancy termination, unless prior approved and pregnancy termination counseling
- Personal care items such as shampoo, mouthwash, or diapers for members, newborn to three years old
- Dietary formulas or diet supplements (unless they are the only source of nutrition and/or medically necessary)
- Medical services to an inmate of a public institution, such as a jail or correction facility
- Care provided by individuals who are not properly licensed or certified and who are not CMDP registered

TIPS FOR TRAVELERS

When traveling, always bring the CMDP ID card. Contact Member Services for help. (Use the toll free phone number, 1-800-201-1795) Even if providers are not registered with CMDP, present the ID card and tell them to bill CMDP. The billing address is on the card. **Do not agree to pay for any services unless you have spoken to CMDP first or it is an emergency.**

Have all prescriptions filled before leaving home. You should have enough medications for the trip or vacation. If you need a pharmacy, use one under contract to CMDP.

If you do not find a pharmacy or a health care provider that is willing to bill CMDP, call Member Services for instructions. If you are asked to pay directly for emergency services, **DO NOT PAY** and see the section below, “*Do Caregivers Pay Anything?*” and call Member Services for more information.

OUT-OF-AREA MOVES

Contact Member Services when you move with a CMDP member from one area, county or to another state. CMDP needs to know the new address for the member. The DCSS, PCP and the DHP should also be contacted.

Advance notice to the PCP and DHP allows time for the transfer of medical files to a new provider. This ensures continuity of care for the member.

If you move with a member to another state, contact the DCSS for assistance in getting health care services in the new state. The caregiver should give CMDP and the DCSS the new address of the member.

The DCSS must tell the new state about the plans to provide health care services for the member. The DCSS will find out if the member can get Medicaid services in the new state. If so, the caregiver is informed how to apply for Medicaid services.

If the member is not eligible, CMDP covers all medically necessary health care services. Provider Services and Member Services Units work with the DCSS to locate and register providers.

Contact Member Services if you need help finding a pharmacy for the member. If you have problems filling your medications contact Medical Services for help.

LEAVING FOSTER CARE

CMDP members who are AHCCCS eligible while in care receive the benefits of an *ex parte* process when leaving care. This provides continued AHCCCS coverage through a transition period (up to 60

days) when they exit care. Members continue health care coverage with another AHCCCS Health Plan until a re-determination is made. CMDP members cannot lose all AHCCCS benefits simply because they have left care.

Additionally, CMDP members that reach the age of 18 years of age and who are AHCCCS eligible while in care receive the benefits of the Young Adult Transitional Insurance (YATI) Program for continued medical coverage with AHCCCS when they exit care. The member's DCSS must complete the AHCCCS enrollment paperwork in order for the member to transition to another AHCCCS Health Plan.

Caregivers and members: Check with the DCSS before members leave care to ensure the *ex parte* process or the YATI Program transition is in place.

DO CAREGIVERS PAY FOR ANYTHING?

There are no payments, fees, or copayments for members or their caregivers. Members and caregivers should not be billed for any services that CMDP covers.

CMDP payments are considered payment in full.

Do not agree to pay for any services unless you have spoken to CMDP first or it is an emergency.

If a member and/or caregiver are billed for a covered service, please contact Member Services. Call Member Services or mail the bill to the attention of Member Services. CMDP will contact the health care provider to address the billing problem.

You may be billed if you ask for a non-covered service and agree in writing to pay for it before you get the service.

If you have to sign any forms, please write all of this information shown below:

(Caregiver's name) for DCS/CMDP

Send all bills or claims to: DCS/CMDP—942C, P.O. Box 29202, Phoenix, AZ 85038-9202

CMDP should be listed as the responsible party. Do not list your home address, phone number or Social Security number on any bills or claims.

NOTE: When the PCP writes a prescription for a brand name medication and a generic medication is available, CMDP covers the cost of the generic. **When the caregiver insists on the brand name medication when a generic is available, the caregiver is responsible for the difference in cost between the generic and the brand name medication.**

WHAT EVERY MEMBER SHOULD KNOW

MEMBER RIGHTS

For members to receive the health care services they need and deserve, members and their caregivers should be aware that **each member will:**

- Be treated with respect and with recognition of the member's dignity and need for privacy:
 - The right to privacy includes protection of any information that identifies a particular member except when otherwise required or permitted by law.

- Not be discriminated against in the delivery of health care services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.
- Have services provided in a culturally competent manner, with consideration for members with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds as well as members with visual or auditory limitation:
 - Options include access to a language interpreter, a person proficient in sign language for the hearing impaired and written materials available in Braille for the blind or in different formats, as appropriate.
- Have the opportunity to choose a primary care provider (PCP), and primary dental provider (PDP) within the limits of the provider network, and choose other providers as needed from among those affiliated with the network:
 - This also includes the right to refuse care from specified providers.
- Participate in decision-making regarding his or her health care, including:
 - The right to refuse treatment (42 CFR 438.100), and/or
 - Have a representative facilitate care or treatment decisions when the member is unable to do so.
- Have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Be provided with information about formulating **advance directives** to provide for involvement by the member or his/her representative in decisions to withhold resuscitative services, or to forgo or withdraw life-sustaining treatment within the requirements of federal and state law with respect to advance directives 42 CFR 438.6. When necessary, advance directives are made by the attorney general's office for member's under the age 18, if they are in care or DCS custody.
- Receive information, in a language and format that the member understands, about member rights and responsibilities, the amount, duration and scope of all services and benefits, service providers, services included and excluded as a condition of enrollment, and other information including:
 - Provisions for after-hours and emergency health care services, which includes the right to access emergency health care services from a provider without prior authorization, consistent with the member's determination of the need for such services as prudent;
 - Information about available treatment options (including the option of no treatment) or alternative courses of care;
 - Procedures for obtaining services, including authorization requirements and any special procedures for obtaining mental health and substance abuse services, or referrals for specialty services not furnished by the member's PCP;
 - Procedures for obtaining services outside the CMDP Preferred Provider Network (PPN);
 - Provisions for obtaining AHCCCS covered services that are not offered or available through CMDP, and notice of the right to obtain family planning services from an appropriate AHCCCS registered provider, and
 - A description of how CMDP evaluates new technology for inclusion as a covered benefit.
 - The criteria used as a basis for decisions. This is available upon request, or it can be viewed on the CMDP web site under the PA Guidelines tab.
- Be provided with information regarding grievances, appeals and requests for a hearing about CMDP or the care provided.

- Have the right to file a complaint to CMDP about inadequate Notice of Action letters or any aspect of CMDP's service.
- Have the right to file a complaint with AHCCCS, Division of Health Care Management, Medical Management Unit if CMDP does not resolve the complaints about the Notice of Action Letter to the member's satisfaction.
- Have the right to file a complaint with AHCCCS about CMDP, if CMDP does not resolve the issue for the member.
- Have access to review his/her medical records in accordance with applicable federal and state laws.
- Have the right to request annually and receive at no cost a copy of his/her medical records as specified in 45 CFR 164.524:
- The member's right of access to inspect and obtain a copy of his/her medical records may be denied if the information is:
 - Psychotherapy notes;
 - Information compiled for, or in reasonable anticipation of, a civil, criminal or administrative action; or
 - Protected health information that is subject to the Federal Clinical Laboratory Improvements Amendments of 1988, or exempt pursuant to 42 CFR 493.3(a)(2).
- An individual may be denied access to read or receive a copy of medical record information without an opportunity for review in accordance with 45 CFR Part 164 (above) if:
 - The information meets the criteria stated above;
 - The provider is a correctional institution or acting under the direction of a correctional institution as defined in 45 CFR 164.501;
 - The information is obtained during the course of current research that includes treatment and the member agreed to suspend access to the information during the course of research when consenting to participate in the research;
 - The information was compiled during a review of quality of care for the purpose of improving the overall provision of care and services;
 - The denial of access meets the requirements of the Privacy Act, 5 U.S.C. 552a; or
 - The information was obtained from someone other than a health care provider under the protection of confidentiality, and access would be reasonably likely to reveal the source of the information.
- Except as provided above, an individual must be informed of the right to seek review if access to inspect or request to obtain a copy of medical record information is denied when:
 - A licensed health care professional has determined the access requested would reasonably be likely to endanger the life or physical safety of the member or another person; or
 - The protected health information makes reference to another person and access would reasonably be likely to cause substantial harm to the member or another person.
- CMDP must respond within 30 days to the member's request for a copy of the records, the response may be the copy of the record or, if necessary to deny the request, the written denial must include the basis for the denial and written information about how to seek review of the denial in accordance with 45 CFR Part 164.

- Have the right to amend or correct his/her medical records as specified in 45 CFR 164.526 (CMDP may require the request be made in writing).
- Have the right to obtain, at no charge, a directory of health care providers in the PPN.
- Have the right to receive information on available treatment options and alternatives, in a manner appropriate to the member's condition and ability to understand.
- Have the right to have a second opinion from a qualified health care professional within the PPN or have a second opinion arranged outside the PPN, only if there is not adequate in-network coverage, at no cost to the member.
- Have the right to know about providers who speak languages other than English.
- Have the right to request information regarding if CMDP has physician incentive plans that affect referral from doctors
- Have the right to know about the type of compensation arrangements with providers, whether stop-loss insurance is required of providers and the right to review member survey results.
- Have the right to request information on the structure and operation of CMDP or CMDP's contractors (42 CFR 438.10(g)(3)(i)).
- The right to contact Member Services if there are any questions regarding member rights.

MEMBER AND CAREGIVER RESPONSIBILITIES

Members and caregivers are responsible for:

- Always listing DCS/CMDP as the responsible party, and the CMDP address for submitting claims (**CMDP - 942C, P.O. Box 29202, Phoenix, AZ 85038-9202**).
- Providing as much information as possible to professional staff working with the member.
- Protecting the member's ID card at all times. Do not lose it or share it with anyone. Show the ID card when checking in for services.
- Following prescribed treatment instructions and guidelines given by those providing health care.
- Knowing the name of the member's PCP or doctor and PDP or dentist.
- Scheduling appointments with the doctor during office hours whenever possible, before using urgent care or a hospital emergency room.
- Scheduling appointments outside of school hours whenever possible.
- Taking the member to medical appointments, or contacting the assigned DCSS or CMDP if you cannot provide transportation.
- Arriving at appointments on time.
- Arriving at the office early if the member is seeing the doctor for the first time
- Notifying the provider at least one day in advance when unable to keep an appointment.
- Carrying the CMDP ID card (or Notice to Provider form, if the card has not arrived) at all times, and presenting it to the health care provider.
- Bringing all available shot records and medical history information to the doctor or PCP.
- Taking the member for well-child checkups.
- Taking the member for a dental exam at least twice a year.
- Using Children's Rehabilitative Services (CRS) when asked to do so by CMDP or the PCP.

- Working with CMDP, the DCSS, the PCP and PDP to make certain the member is receiving the best care possible.
- Ensuring that each member has all childhood and teenage immunizations (shots) and exams appropriate to the child's age and health (EPSDT exams). (See the Center for Disease Control and Prevention website for immunization schedules and more information at <http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html>).

SERVICES CAREGIVERS CANNOT AUTHORIZE

- General anesthesia
- HIV testing, if the member is under age 12 (members over age 12 can self-consent)
- Blood transfusions
- Pregnancy termination
- Any surgery or medical treatment that is not routine

MAINTAINING GOOD HEALTH

How to help keep members healthy:

- Make sure all members have a shot record. Be sure shots are up-to-date (See the Center for Disease Control and Prevention website for immunization schedules and more information at <http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html>).
- Follow up on all referrals made during visits with the Primary Care Provider (PCP), including those for dental, vision care and therapies.
- Members should wear good fitting shoes. This will help prevent injury or infection.
- Keep fingers and toenails clean. This will help prevent infections.
- Sometimes you need to go to a new doctor. When this happens make sure to get copies all medical records sent to the new doctor.
- The teen member's doctor should talk about birth control with them. They should also talk about safe sex. Safe sex includes how to prevent sexually transmitted diseases. The member's caregiver should also talk to them about these subjects.
- Members should go to all prenatal care appointments. Make sure all postpartum doctor visits are kept after the baby is born.

MEMBER CONFIDENTIALITY AND HIPAA NOTICE

The privacy of our members' medical information is very important to CMDP; we want to keep our members information private and confidential. For example, CMDP verifies the identity of all incoming callers before releasing any information. Our Member Services staff will only give information to the member's legal guardian (custodial agency representative), the member's caregiver and/or the member. Any other callers requesting information are referred to the member's legal guardian for further assistance. The Health Insurance Portability and Accountability Act (HIPAA) affects health care in several ways. CMDP is required to have safeguards for protecting members' health information. This applies to all health care providers and other stakeholders.

A member's Protected Health Information (PHI) may be used for treatment, payment and health plan operations and as permitted by law. The member or the legal guardian must give written approval for any non-health care uses of PHI.

CMDP provides a notice of members' rights and responsibilities on the use, disclosure and access to PHI. It is called the "Notice of Privacy Practices" (NPP). The NPP is sent to the legal guardians of CMDP members. It is also included in the New Member Packets. Anyone can request the NPP by calling the CMDP **Privacy Officer** or downloading it from www.azdes.gov/hipaa.

The CMDP **Privacy Officer** explains the NPP and answers questions about HIPAA. Call (602) 351-2245 or 1-800-201-1795 and ask to speak to the Privacy Officer.

CMDP MEMBER ADVOCATES

An advocate is anyone who supports and promotes the rights of the member. Listed below are advocates for members in foster care:

- The member's DCSS (Legal Guardian), the Supervisor or the Program Manager of the DCSS and Supervisor
- The member's Juvenile Justice Probation or Parole Officer
- The Assistant Attorney General (AAG) assigned to the members' case
- The Arizona Center for Disability Law (a non-profit public interest law firm dedicated to protection and advocacy of individuals with disabilities. The website address for more information is www.acdl.com. The phone number is (602) 274-6287, and toll free 1(800) 927-2260.
- Arizona Ombudsman-Citizens Aide (If you feel you have been treated unfairly by a state administrator, if you find yourself in a disagreement or dispute with a state agency or department you can turn to the ombudsman-citizen aide. The website address for more information is www.azleg.gov/ombudsman. The phone number is (602) 277-7292; toll free 1(800) 872-2879.
- The child's PCP or doctor

FRAUD AND ABUSE

Fraud is defined by CMDP as an intentional act made with the knowledge that it could result in some unauthorized benefit.

Abuse is defined as the action of a provider that does not meet sound business or medical practices. The result is payment by CMDP for services that do not help a member feel better (medically necessary).

An example of provider fraud and abuse is a doctor billing for services that were not given to the member or services that the member did not need.

An example of member fraud and abuse is loaning, giving or selling CMDP ID cards to others. Contact Member Services if you feel fraud or abuse has occurred, by calling (602) 351-2245, or 1(800) 201-1795, Option 3-1.

The CMDP Fraud and Abuse Coordinator reviews and refers incidents of potential fraud and abuse to the AHCCCS Office of Program Integrity (OPI). Members and foster caregivers have the option of referring potential incidents to the OPI directly at (602) 417-4193. Penalties for persons involved in fraud and/or abuse may be both civil and criminal.

GRIEVANCES AND APPEALS

A **grievance** is a complaint, which means an expression of dissatisfaction about any matter other than an action. Grievances include, but are not limited to, the quality of care or services provided, rudeness of a provider or employee, or failure to have a member's rights respected.

A member or an authorized representative (the DCSS or juvenile justice representative) can file a grievance. A provider can file a grievance on the member's behalf, but **only** with the written consent of the member's authorized representative.

A grievance can be filed at any time either orally or in writing to CMDP. To file a grievance by phone, call Member Services. To file a grievance in writing, you can send an e-mail to **CMDPMemberServices@azdes.gov**, or you can send a letter to:

CMDP
Attn: Member Grievances
Site Code 942C
P.O. Box 29202
Phoenix, AZ 85038-9202

A disposition will be completed and provided no later than 90 days after the day CMDP received the grievance. A grievance resolution/response cannot be appealed or be the subject of a hearing.

Call the Member Services Manager at (602) 351-2245 or 1(800) 201-1795 if you have any questions or need more information.

A **Notice of Action** is a response from CMDP regarding a requested service. If a member disagrees with the Notice of Action response, the member or an authorized representative can file an appeal. An action documented on the Notice of Action by CMDP includes, but is not limited to the following:

- The denial or limited authorization of a requested service, including the type or level of service
- The reduction, suspension, or termination of a previously authorized service
- Denial, in whole or in part, of payment for a service
- The right to file a complaint to CMDP about inadequate Notice of Action letters

An **appeal** is a request for review of an action. (See definition of an action listed above.) Appeals can be filed either orally or in writing within 60 days after the date of the Notice of Action. Information on how to file an appeal is given with the denial, reduction, suspension or termination of service notice, or the Notice of Action form. If you would like to file an appeal in writing, send a letter to:

CMDP
Attn: Dispute and Appeal Manager
Site Code 942C
P.O. Box 29202
Phoenix, AZ 85038-9202

Call the Dispute and Appeal Manager at (602) 351-2245 or 1(800) 201-1795 if you have any questions or need more information.

CMDP makes a final decision on appeals within 30 days of receiving a written or oral appeal. A letter will be mailed to the *appellant* (whomever filed the appeal), stating CMDP's decision and the reason for the decision.

Members who believe that their life or health could be in danger by waiting 30 days the member or authorized representative can request an **expedited appeal**.

An expedited appeal is a faster review. The member's health care provider **must** provide documentation to support the request for an expedited appeal. A decision on an expedited appeal is provided within 3 working days.

Sometimes more information is needed to make an appeal decision. If a decision cannot be made in time, a 14 day extension may be requested. This can be done by the member, authorized custodial agency representative or CMDP.

If the member or authorized representative disagrees with a decision that CMDP has made on an appeal, a State Fair Hearing can be requested.

The member or authorized representative can request a State Fair Hearing by writing CMDP no later than 30 days after receiving the appeal decision. CMDP will forward the case file and information to the AHCCCS Office of Administrative Legal Services (OALS). If the member or authorized representative has questions or needs more information regarding a State Fair Hearing, contact the Dispute and Appeal Manager at (602) 351-2245 or 1(800) 201-1795.

The member or authorized representative may request continuation of services while the appeal is pending. The services will continue if:

- The appeal is filed timely
- The appeal involves the termination, suspension or reduction of previously authorized services
- Services were authorized by CMDP
- Original period covered by original authorization has not expired
- The member requests and CMDP approves that services continue

Requests for continuation must be filed within 10 days after the date CMDP mailed the "Notice of Action" or the effective date of the action as indicated in the "Notice of Action."

BEHAVIORAL HEALTH GRIEVANCES

If there is a concern about the behavioral health services the member is receiving, contact the DCSS, juvenile justice representative, DCS Behavioral Health Clinical Coordinator or a CMDP Behavioral Health Coordinator to determine if the services are being paid by CMDP or the Arizona Department of Health Services - Regional Behavioral Health Authority (ADHS-RBHA).

If the member is getting services paid by CMDP, the CMDP Behavioral Health Coordinator will help contact the CMDP Dispute and Appeal Manager to resolve a grievance. Call the Behavioral Health Coordinators at (602) 351-2245 or 1(800) 201-1795, Option 3-2.

If the member is getting services paid by the RBHA, contact the patient representative at the RBHA.

If the member and caregiver are not happy with the decision, there is the right to file an appeal with the RBHA. Ask your DCSS or the juvenile justice representative for help.

CORPORATE COMPLIANCE

The Corporate Compliance Program outlines the legal and ethical behavior of CMDP employees. The CMDP Code of Conduct cannot cover every situation, nor is it a substitute for common sense, individual judgment and personal integrity. It is the duty of each CMDP employee to follow these principles:

- Respect the rights, dignity and diversity of each individual
- Maintain the appropriate levels of confidentiality for information and documents

- Comply with all applicable laws
- Conduct CMDP affairs in accordance with the highest ethical standards
- Ensure proper payment for services
- Avoid conflicts of interest
- Provide a safe working environment
- Provide equal opportunity to each employee
- Promote open communication
- Conduct all business with honesty and integrity

CORPORATE COMPLIANCE HOTLINE

The CMDP Corporate Compliance Hotline is the confidential voice mailbox of the CMDP Compliance Officer. It is available 24 hours a day, 7 days a week. Anyone can use this resource to report, in good faith, concerns involving CMDP employees and potential fraud, unethical, illegal or unacceptable practices or compliance violations.

All calls are kept confidential to the extent permitted by law. Although the caller is encouraged to identify him or herself, the call can be an anonymous report. The CMDP Compliance Officer will investigate all reports of improper conduct, and take action equitably and consistently. Reports can be made by calling CMDP and asking for the Corporate Compliance Officer at (602) 351-2245 or 1(800) 201-1795.

Safe Sleep for Babies

What Does a Safe Sleep Environment Look Like For Babies?

The following are safe sleep guidelines to reduce the risk of Sudden Infant Death Syndrome (SIDS) and other sleep related causes of infant death:

- Always place the baby on their back for safe sleeping
- Use safety-approved crib, covered by a fitted sheet
- No pillows, blankets, sheepskins, or crib bumpers
- No soft objects, toys, and loose bedding near the baby's sleep area
- No smoking around the baby
- Baby should not sleep in an adult bed, on a couch, or on a chair alone or with you, and
- Nothing should cover or be near the baby's head
- http://www.nichd.nih.gov/publications/pubs/Documents/Safe_Sleep_Environment_English.pdf
- https://www.nichd.nih.gov/publications/pubs/Documents/Cual_apariencia_ambiente_espanol_2013.pdf

Remember that the substance-exposed newborn is at much greater risk of Sudden Unexplained Death and Sudden Infant Death Syndrome (SIDS). So, safe sleep is very important for this group of infants. For more information on the care of the substance-exposed newborn, please see: <https://www.azdes.gov/InternetFiles/Pamphlets/pdf/CSO-1072A.pdf>

Let's keep babies safe while they sleep!

RECOMMENDED IMMUNIZATION SCHEDULES

Caregivers in the State of Arizona are obligated to abide by the statutes governing the health of children in care. Article 58, of the Arizona Administrative Code, R6-5-5830, Medical and Dental Care, states: “A caregiver shall arrange for a foster child to have routine medical and dental care, which shall include an annual medical exam, semi-annual dental exams, immunizations and standard medical tests.” (See the Center for Disease Control and Prevention website for immunization schedules and more information at <http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html>).

Arizona law requires school children and childcare enrollees to be age-appropriately immunized. The exceptions and additions to the rules are as follows:

- Biological parents whose religious beliefs do not allow immunizations must sign a religious exemption.
- The child’s doctor must sign a medical exemption form if there is evidence of immunity or a medical reason why the child cannot receive shots. A copy of the lab results must be kept on file to prove the child’s immunity.

Vaccine reactions rarely happen and usually are no worse than minor flu symptoms. Serious reactions are very rare. The dangers of not being immunized are far worse than the possibility of serious reaction.

PRE-TEEN/TEEN VACCINES

As children get older the vaccines they got when they were young can begin to wear off. They are also at risk for even more illnesses. Help your child grow into their teens in a healthy way. Do this by staying up to date on pre-teen vaccines. Check with your teen’s doctor to make sure he/she has had all of these vaccines:

- Meningococcal
- Pertussis booster (Tdap),
- Human Papillomavirus (HPV)
- Hepatitis B
- Measles, Mumps, and Rubella (MMR)
- Polio
- Varicella

You can call the EPSDT Coordinator at (602) 351-2245. You can also reach them at 1(800) 201-1795. Pick option 3-4, if you would like a Lifetime Immunization Card. You can use this card to keep track of all the vaccines your CMDP member gets.

(See the Center for Disease Control and Prevention website for immunization schedules and more information at <http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html>).

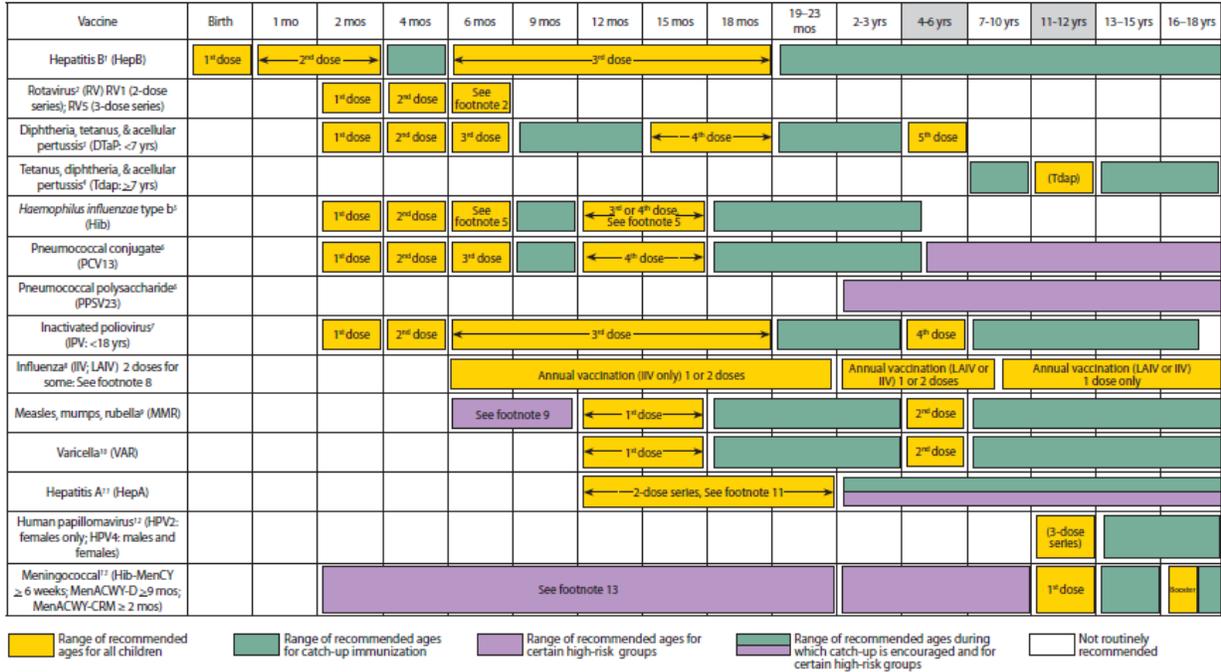
Note: The recommended immunization schedules as of January 1, 2015 (shown on the following pages) are periodically changed by the Centers for Disease Control and Prevention. Discuss your CMDP member’s immunizations with the PCP or doctor.

When Do Children and Teens Need Vaccinations?

Figure 1. Recommended immunization schedule for persons aged 0 through 18 years – United States, 2015.

(FOR THOSE WHO FALL BEHIND OR START LATE, SEE THE CATCH-UP SCHEDULE (FIGURE 2)).

These recommendations must be read with the footnotes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars in Figure 1. To determine minimum intervals between doses, see the catch-up schedule (Figure 2). School entry and adolescent vaccine age groups are shaded.



This schedule includes recommendations in effect as of January 1, 2015. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at <http://www.cdc.gov/vaccines/hcp/acip-recs/index.html>. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (<http://www.vaers.hhs.gov>) or by telephone (800-822-7967). Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for vaccination, is available from CDC online (<http://www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm>) or by telephone (800-CDC-INFO [800-232-4636]).

This schedule is approved by the Advisory Committee on Immunization Practices (<http://www.cdc.gov/vaccines/acip/>), the American Academy of Pediatrics (<http://www.aap.org>), the American Academy of Family Physicians (<http://www.aafp.org>), and the American College of Obstetricians and Gynecologists (<http://www.acog.org>).

NOTE: The above recommendations must be read along with the footnotes of this schedule.

CATCH-UP IMMUNIZATION SCHEDULE

Figure 2. Catch-up Immunization Schedule for persons aged 4 months through 18 years who start late or who are more than one month behind – United States, 2015

The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child’s age. Always use this table in conjunction with Figure 1 (previous page) and the footnotes that follow.

FIGURE 2. Catch-up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind—United States, 2015.
The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child’s age. Always use this table in conjunction with Figure 1 and the footnotes that follow.

Children age 4 months through 6 years					
Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Hepatitis B ¹	Birth	4 weeks	8 weeks and at least 16 weeks after first dose. Minimum age for the final dose is 24 weeks.		
Rotavirus ²	6 weeks	4 weeks	4 weeks ²		
Diphtheria, tetanus, and acellular pertussis ³	6 weeks	4 weeks	4 weeks	6 months	6 months ³
Haemophilus influenzae type b ⁴	6 weeks	4 weeks if first dose was administered before the 1 st birthday. 8 weeks (as final dose) if first dose was administered at age 12 through 14 months. No further doses needed if first dose was administered at age 15 months or older.	4 weeks ⁴ if current age is younger than 12 months and first dose was administered at younger than age 7 months, and at least 1 previous dose was PRP-1 (ActHib, Pentacel) or unknown. 8 weeks and age 12 through 59 months (as final dose) ⁵ - if current age is younger than 12 months and first dose was administered at age 7 through 11 months; - if current age is 12 through 59 months and first dose was administered before the 1 st birthday, and second dose administered at younger than 15 months; - if both doses were PRP-OMP (PedvaxHB, Comvax) and were administered before the 1 st birthday. No further doses needed if previous dose was administered at age 15 months or older.	8 weeks (as final dose) This dose only necessary for children age 12 through 59 months who received 3 doses before the 1 st birthday.	
Pneumococcal ⁶	6 weeks	4 weeks if first dose administered before the 1 st birthday. 8 weeks (as final dose for healthy children) if first dose was administered at the 1 st birthday or after. No further doses needed for healthy children if first dose administered at age 24 months or older.	4 weeks if current age is younger than 12 months and previous dose given at <7 months old. 8 weeks (as final dose for healthy children) if previous dose given between 7-11 months (wait until at least 12 months old); OR if current age is 12 months or older and at least 1 dose was given before age 12 months. No further doses needed for healthy children if previous dose administered at age 24 months or older.	8 weeks (as final dose) This dose only necessary for children aged 12 through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age.	
Inactivated poliovirus ⁷	6 weeks	4 weeks ⁷	4 weeks ⁷	6 months ⁷ (minimum age 4 years for final dose).	
Meningococcal ¹³	6 weeks	8 weeks ¹³	See footnote 13	See footnote 13	
Measles, mumps, rubella ⁸	12 months	4 weeks			
Varicella ⁹	12 months	3 months			
Hepatitis A ¹¹	12 months	6 months			
Children and adolescents age 7 through 18 years					
Tetanus, diphtheria, tetanus, diphtheria, and acellular pertussis ³	7 years ⁴	4 weeks	4 weeks if first dose of DTaP/DT was administered before the 1 st birthday. 6 months (as final dose) if first dose of DTaP/DT was administered at or after the 1 st birthday.	6 months if first dose of DTaP/DT was administered before the 1 st birthday.	
Human papillomavirus ¹²	9 years		Routine dosing intervals are recommended. ¹²		
Hepatitis A ¹¹	Not applicable (N/A)	6 months			
Hepatitis B ¹	N/A	4 weeks	8 weeks and at least 16 weeks after first dose.		
Inactivated poliovirus ⁷	N/A	4 weeks	4 weeks ⁷	6 months ⁷	
Meningococcal ¹³	N/A	8 weeks ¹³			
Measles, mumps, rubella ⁸	N/A	4 weeks			
Varicella ⁹	N/A	3 months if younger than age 13 years. 4 weeks if age 13 years or older.			

NOTE: The above recommendations must be read along with the footnotes of this schedule.

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
VISION PERIODICITY SCHEDULE**

PROCEDURE/AGE	New born	3-5 days	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	3 yr	4 yr	5 yr	6 yr	7 yr	8 yr	9 yr	10 yr	11 yr	12 yr	13 yr	14 yr	15 yr	16 yr	17 yr	18 yr	19 yr	20 yr	
Vision +	S	S	S	S	S	S	S	S	S	S	S	O*	O	O	O	S	O	S	O	S	O	S	S	O	S	S	O	S	O	S

These are minimum requirements: If at any time other procedures, tests, etc. are medically indicated, the physician is obligated to perform them.

- Key:**
- S = Subjective, by history
 - O = Objective, by a standard testing method
 - * = If the member is uncooperative, rescreen in 6 months.
 - + = May be done more frequently if indicated or at increased risk.

Ocular photoscreening with interpretation and report, bilateral 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.

Revised: 04/01/15, 04/01/2014, 4/1/2007, 8/1/2005

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
HEARING/SPEECH SCHEDULE**

PROCEDURE/AGE	New born	3-5 days	2 Wks	By 1mo	6 Wks	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	3 yr	4 yr	5 yr	6 yr	7 yr	8 yr	9 yr	10 yr	11 yr	12 yr	13 yr	14 yr	15 yr	16 yr	17 yr	18 yr	19 yr	20 yr
Hearing/Speech +	O**	S	O**			S	S	S	S	S	S	S	S	S	O	O	O	S	O	S	O	S	O	S	S	O	S	S	O	S	S

These are minimum requirements: If at any time other procedures, tests, etc. are medically indicated, the physician is obligated to perform them.

- Key:**
- S = Subjective, by history
 - O = Objective, by a standard testing method
 - * = All children, including newborns, meeting risk criteria for hearing loss should be objectively screened.
 - + = May be done more frequently if indicated or at increased risk
 - ** = All newborns should be screened for hearing loss at birth and again 2 to 6 weeks afterward if indicated by the first screening or if a screening was not completed at birth.

Revised: 04/01/15, 04/01/2014, 4/1/2007, 8/1/2005

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
DENTAL PERIODICITY SCHEDULE
Recommendations for Preventative Pediatric Oral Health Care***

PROCEDURES				
	12 - 24 mos.	2 - 6 years	6 - 12 years	12+ years
Clinical oral examination including but not limited to the following: [†]				
• Assess oral growth and development	X	X	X	X
• Caries risk assessment	X	X	X	X
• Assess need for fluoride supplementation	X	X	X	X
• Anticipatory guidance / counseling	X	X	X	X
• Oral hygiene counseling	X	X	X	X
• Dietary counseling	X	X	X	X
• Injury prevention counseling	X	X	X	X
• Counseling for nonnutritive habits	X	X	X	X
• Substance abuse counseling			X	X
• Counseling for intraoral / perioral piercing			X	X
• Assessment for pit and fissure sealants		X	X	X
Radiographic assessment	X	X	X	X
Prophylaxis and topical flouride	X	X	X	X

These recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations may require modification for children with special health care needs. As in all medical care, dental care must be based on the individual needs of the patient and the professional judgment of the oral health provider.

Parents or caregivers should be included in all consultation and counseling of members regarding preventative oral health care and the clinical findings.

[†]First examination is encouraged to begin by age 1. Repeat every 6 months or as indicated by child's risk status / susceptibility to disease.

*Adapted from the American Academy of Pediatric Dentistry Schedule.

Initial effective date: 10/01/2008

Surround Your Loved Ones With A Vaccinated Family

VACCINATE YOUR FAMILY MEMBERS AGAINST PERTUSSIS (WHOOPIING COUGH)

What Is Pertussis?

- Pertussis is a serious illness. People who have this illness can have a runny nose, mild fever and a cough. The cough can turn into bad coughing spells. The illness can last six or more weeks.
- Did you know that Pertussis is especially dangerous for newborns? This is because they are too young to get the Pertussis vaccine?
- The illness causes infants to cough so much, that some have trouble breathing. This can lead to hospitalization with a risk of death.

Not Just Kids Are At Risk

- Family members can spread pertussis to their own babies. They can also spread it to people who can't be immunized.
- Pregnant women can protect their babies by getting a Tdap vaccine during every pregnancy.
- Anyone who has not been vaccinated against pertussis (Tdap vaccine) is at a higher risk of getting Pertussis and passing it on to an infant or child.

Protect Your Family

- Vaccinate family members with a Tdap vaccine to protect against Pertussis.
- Don't forget that this includes your teens, grandparents and close family friends.
- Talk to your doctor or call your health plan for Tdap vaccine information.

LOCATE a Tdap vaccine **CALL 2-1-1** **VISIT** WhyImmunize.org

Rodea A Sus Seres Queridos Con Una Familia Vacunada

VACUNE A SUS MIEMBROS DE FAMILIA CONTRA PERTUSIS (TOSFERINA)

¿Qué es Tosferina o Pertusis?

- Pertusis es una enfermedad seria. Los síntomas pueden incluir: nariz que gotea, gripa no muy fuerte, y tos. La tos entonces se convierte en una tos severa que puede durar seis o más semanas.
- Sabía usted que la Pertusis es especialmente peligrosa en los recién nacidos porque están muy pequeños para recibir la vacuna de Pertusis?
- La enfermedad causa a los infantes toser tanto, que algunos tienen problemas al respirar lo que resulta en llegar a ser hospitalizados y posiblemente la muerte.

No Solo Los Niños Están En Peligro

- Los familiares pueden extender la tosferina sin saberlo a los mas vulnerables, su propio bebé o las personas que no pueden ser vacunados.
- Las mujeres embarazadas pueden proteger a sus bebés al conseguir la vacuna Tdap durante cada embarazo.
- Cualquiera que no haya sido vacunado contra la Tosferina (vacuna Tdap está en mayor riesgo de contraer la enfermedad y contagiar a niños.

Proteja A Su Familia

- Vacune a sus miembros de familia con la vacuna Tdap para protegerlos contra el Pertusis.
- No olvide que esto incluye a los adolescentes, abuelos, amigos, y familiares cercanos.
- Hable con su doctor o llame a su plan de salud para información acerca de la vacuna Tdap.

LOCALICE una vacuna Tdap **LLAME** 2-1-1 **VISITE** WhyImmunize.org