AHCCCS Policy Changes – Dental Restorations

Primary Dentition
Arizona Health Care Cost Containment System (AHCCCS) policy change states:
Restorations of anterior teeth are covered for children under the age of five, when medically neces-
sary. Children, five years and over with primary anterior tooth decay should be considered for ex-
traction, if presenting with pain or severely broken down tooth structure, or be considered for obser-
vation until the point of exfoliation as determined by the dental provider.

AHCCCS policy pertains to the maxillary and mandibular central and lateral incisors. The designated
teeth are (#D, E, F, G) and (#N, O, P, Q).

AHCCCS administration has placed an age limitation from 0 through 4 years regarding the resto-
ration of anterior primary teeth.
Covered services for members through 4 years:
  • prefabricated resin crown (D2932)
  • prefabricated stainless steel crown with resin window (D2933)
  • prefabricated esthetic coated stainless steel crown (D2934)
  • resin-three surfaces (anterior) (D2332)
  • resin-four or more surfaces or involving incisal angle anterior (D2335)

Permanent Dentition
AHCCCS policy change has placed a minimum age of 18 years regarding specific crown restorations
of permanent teeth.
Covered services for members 18-20 years:
  - Crown – titanium (D2794) with completed root canal therapy
  - Provisional crown (D2799)

AHCCCS Policy Manual (AMPM), Oral Health Services, can be referenced at:

Dr. Jerry Caniglia
CMDP Dental Consultant
Remember EPSDT and an EP Modifier
Go Hand in Hand

Effective April 1, 2014, AHCCCS requires the use of an EP modifier on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) visits. EPSDT visits are paid at a global rate and Providers must use an EP modifier to designate all services related to the EPSDT well child check-ups, including routine vision and hearing screenings. Appropriate vision, hearing, and speech screenings are covered during an EPSDT visit. Payment for vision and hearing exams, include but are not limited to the following Current Procedural Terminology (CPT) Codes:

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<thead>
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<td>99174</td>
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</tbody>
</table>

Any other procedure that may be interpreted as fulfilling the vision and hearing requirements provided in a Primary Care Provider’s (PCP) office during an EPSDT visit are considered part of the EPSDT visit and are not a separately billable services. Also payment for laboratory services that are not separately billable and considered part of the payment made for the EPSDT visit include but are not limited to:

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Please utilize the following link and refer to chapter 400 to review the new requirements


Contact CMPD Claims Department with any further questions at 602-351-2245.
EPSDT to Improve Child Health

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program has been shaped to fit the standards of pediatric care and to meet the special physical, emotional, and developmental needs of children. Since 1967, the purpose of the EPSDT program has been "to discover, as early as possible, the health problems that impact our children" and to provide "continuing follow up and treatment so that their healthcare needs are met.

The elements of EPSDT:

<table>
<thead>
<tr>
<th>Early</th>
<th>Identifying problems early, starting at birth</th>
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<tbody>
<tr>
<td>Periodic</td>
<td>Checking children's health at periodic, age-appropriate intervals</td>
</tr>
<tr>
<td>Screening</td>
<td>Doing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems</td>
</tr>
<tr>
<td>Diagnostic</td>
<td>Performing diagnostic tests to follow up when a risk is identified,</td>
</tr>
<tr>
<td>Treatment</td>
<td>Treating the problems found.</td>
</tr>
</tbody>
</table>

EPSDT is a mandatory set of services and benefits for all individuals under age 21 who are enrolled in Medicaid. Think of it as the well-child health coverage package of Medicaid.

What is Covered Under EPSDT:

Screening services "to detect physical and behavioral health conditions" must be covered at established, periodic intervals and whenever a problem is suspected.

Screening includes a comprehensive health and developmental history, an unclothed physical exam, appropriate immunizations, laboratory tests, and health education.

In addition, dental, vision, and hearing services are required, including appropriate screening, diagnostic, and treatment. Federal law states that treatment must include any "necessary health care, diagnostic services, treatment, and other measures" that are needed to "correct or improve defects and physical and mental illnesses and conditions discovered by the screening services."

Visit the below link for additional information.

http://mchb.hrsa.gov/epsdt/requirements.pdf

FDA Alerts - Black Box Warnings

Three Drugs Recalled during from October 2013-July 2014:

**Iclusig:** was discontinued due to the risk of blood clots and narrowing of blood vessels. Iclusig was approved for the treatment of chronic, accelerated or blast-phase chronic myeloid leukemia (CML) or Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL)

**Advocate Redi-code+ BMB-Ba006A blood glucose test strips:** was recalled due to not being compatible with certain Advocate glucometers causing an incorrect glucose result.

**Genstrip blood glucose test strips:** recalled due to supplier, Shasta Technologies LLC, being in violation of quality control which could cause the test strips to report inaccurate blood glucose levels.

None of CMDP’s members were affected by these recalls.
Asthma

Asthma is one of the most common chronic diseases in childhood. The primary care and emergency visits that are in result of Asthma complications have significant implications for the families of children with asthma, for schools and for the healthcare system. According to the Healthy Children website more than 23 million Americans have the condition asthma and more than one-quarter of them are children younger than 18 years.

Good asthma self-management improves long-term asthma outcomes and behavioral modification. Providers should:

- Routinely review each patient’s asthma action plan and assess understanding and adherence to the plan and medication regimen
- Develop partnerships with patients
- Educate, beginning at diagnosis; reinforce and review understanding
- Educate to the child’s developmental level and understanding
- Review the signs and symptoms of good asthma control versus poor control
- Review the role of asthma medication and continually instruct on the proper use of inhalers
- Review strategies for trigger avoidance
- Observe medication delivery during a face-to-face visit; do not rely on printed materials alone

Proper documentation affects reimbursement. International Classification of Diseases (ICD-9) and Current Procedural Terminology (CPT) Codes must be adequately supported by chart documentation to ensure optimal and timely reimbursement. Asthma education is integral to moving the treatment of this disease away from a focus on acute-care needs and toward improved long-term patient outcomes.

If CMDP can be of any assistance, please contact the Medical Services Unit.

http://www.healthychildren.org/English/health-issues/conditions/allergies-asthma/Pages/Asthma.aspx

Synagis Updates

The American Academy of Pediatrics (AAP) released updated 2014 recommendations regarding usage of Palivizumab. Palivizumab is used in the prevention of Respiratory Syncytial Virus (RSV) infections and is recommended for infants at high-risk due to prematurity or other medical problems such as congenital heart disease.

The major points of revision include:

- Palivizumab prophylaxis is now recommended for infants born only at less than 29 weeks gestation.
- Palivizumab is not recommended for otherwise healthy infants born at or after 29 weeks gestation.
- Infants with chronic lung disease (CLD) of prematurity qualify for prophylaxis only if they require supplemental oxygen for more than 28 days after birth.
- With rare exception as defined in this policy statement, prophylaxis is not recommended during the second year of life.
- Monthly prophylaxis should be discontinued in any infant or young child who experiences a breakthrough Respiratory Syncytial Virus (RSV) hospitalization.

CMDP will be updating our guidelines for Synagis administration within the following weeks. This will be placed on the CMDP website at www.azdes.gov/cmdp. Please, visit our website for this and any future updates. For additional information: www.aap.org/en-us/about-the-aap/aap-press-room/Pages/AAP-Updates-Recommendations-for-Use-of-Palivizumab-Against-RSV
What You Should Know for the 2014-2015 Influenza Season

Influenza Vaccine General Facts:

- Influenza vaccines will be of the same antigenic composition as the previous season
- People should continue to get yearly immunization even if they were vaccinated last year
- There should be an ample supply of vaccines and this year the Vaccines For Children (VFC) program will only have quadrivalent flu vaccine
- If everything goes as indicated by manufacturers, shipments may begin as early as July or August and continue throughout September and October until all of the vaccine is distributed.

When will flu activity begin and when will it peak?

The timing of flu is very unpredictable and can vary from season to season. Flu activity most commonly peaks in the U.S. in January or February. However, seasonal flu activity can begin as early as October and continue to occur as late as May.

What should I do to prepare for this flu season?

The Centers for Disease Control and Prevention (CDC) recommends yearly flu vaccine for everyone 6 months of age and older as the first and most important step in protecting against this serious disease. Doctors and nurses are encouraged to begin vaccinating their patients soon after vaccine becomes available, preferably by October so as not to miss out on opportunities to vaccinate. Those children aged 6 months through 8 years who need two doses of vaccine should receive the first dose as soon as possible to allow time to get the second dose before the start of flu season. The two doses should be given at least 4 weeks apart. Providing your patients with the flu vaccine before the start of seasonal flu activity each year is always a good idea, and the protection they get from vaccination will last throughout the flu season.

In addition to getting vaccinated, remind your patients and their caregivers of the everyday preventive steps they can take to protect themselves and others. Steps like staying away from sick people and washing their hands to reduce the spread of germs. If they are sick with flu, they should stay home from work or school to prevent spreading flu to others.

Special note: Remember to have your staff enter the Flu shots into the Arizona State Immunization Information System (ASIIS)

Prescribing Cefdinir

In order to decrease the rate of inappropriately prescribing Cefdinir in children with an initial diagnosis of Otitis Media (OM), CMDP recommends using first-line antibiotics when possible. Once a child is identified as having an OM, CMDP recommends the clinical practice of prescribing a high dose amoxicillin as per AAP practice guidelines.

For further questions please contact Medical Services at 602-351-2245.

Thank you for your continued support in providing optimal patient care to our children and youth!

References
Arizona Best Practices for Children in Care

The Arizona Health Care Cost Containment System (AHCCCS) Medical Policy Manual (AMPM) procedures and guidelines specify the process Primary Care Physicians (PCP) use to assess for psychiatric diagnoses and prescribing behavioral health medications for children in care. The Comprehensive Medical and Dental Program (CMDP) covers PCP prescriptions for those children diagnosed with ADHD, Depression, and Anxiety. It is the role and responsibility of PCP’s to create and refer specialty care patients to a Behavioral Health Medical Practitioner (BHMP), per AHCCCS policy.

Behavioral Health Medical Practitioners apply the 12 Arizona Principles outlined in the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) Practice Protocol in order to meet the behavioral health needs of children in care. Due to the unique and sometimes complex needs of children in care, psychiatric disorders are often misdiagnosed since it is difficult to differentiate between symptoms of trauma and symptoms of other psychiatric disorders. Collaboration and communication is vital to the development and treatment of a psychiatric diagnosis and requires a clinician to spend extra time with the child to possibly participate in Child and Family Team meetings (CFT), coordinate care, and provide continuous outreach to involve community/school support professionals in the treatment planning process. It is best practice for the special BH needs of children in care to be monitored and managed by BHMP’s and clinicians, making a referral for services a critical component in eliminating quality of care issues and aiding in the future success of our patients.

AHCCCS Medical Policy Manual:

12 Arizona Principles:
http://www.azdhs.gov/bhs/children/jk.htm

CMDP and Psychotropic Oversight

In accordance with the new AHCCCS Medical Policy Manual (AMPM) AHCCCS requirements, Chapter 400, Policy 430, Primary Care Providers (PCP’s) who prescribe medications to treat Attention Deficit Hyperactivity Disorder (ADHD), depression, and/or anxiety disorders must complete an annual assessment of the member’s behavioral health condition and treatment plan. CMDP will complete annual assessment and treatment plan audit for every psychotropic prescription.

The CMDP Psychotropic Oversight Audit Tool has been included in this newsletter on page 7 for your reference. CMDP’s Audit Tool is designed to ensure the PCP’s assessment and treatment plan follows best practices, which includes informed consent, follow-up appointments, psychosocial interventions, and documentation that the child’s trauma history was considered as part of the differential diagnosis.

- For treatment of ADHD, best practice includes a neurological exam, comorbidity screen (such as for Tic disorder), objective testing (such as Vanderbilt Assessment Scale), and a Regional Behavioral Health Authority (RBHA) referral if the patient is under 6 years old.
- For treatment of depression, best practice includes a Danger to Self/Danger to Others risk assessment, objective testing (such as Beck Depression Inventory), and a RBHA referral if the patient is under 8 years old.
- For treatment of anxiety, best practice includes documentation of differential diagnosis that rules out other anxiety disorders, objective testing, and a RBHA referral if the patient is under 8 years old.

Below are the links to the AHCCCS AMPM requirements as well as AHCCCS toolkits for PCP’s prescribing medications to children to treat ADHD, depression, and anxiety.

AHCCS AMPM link:

AHCCCS Tool Kit Link - Anxiety:

AHCCCS Tool Kit Link – Depression:

AHCCCS Tool Kit Link – ADHD:
CMDP Psychotropic Medication Oversight
Assessment and Treatment Plan Annual Audit Tool

GENERAL

☐ Informed Consent for medication:
  ☐ Risks / Benefits of medication use
  ☐ Side Effects of medications discussed
  ☐ Potential Complications of medications

☐ Follow Up Interval Established to titrate medications appropriately
☐ Referral to Psychosocial Interventions
☐ Document History of Trauma present or assessed and not present

ADHD

☐ Neurological Exam documented
  ☐ Screen for Co-Existing Behavioral Health Disorder
    ☐ e.g., Tic Disorder
☐ Objective Testing (e.g. Vanderbilt Assessment Scale)
☐ Requires RBHA Referral if the child is < 6 years

Depression

☐ DTS/DTO (Danger to Self / Danger to Others) Risk Assessment
  ☐ If positive—RBHA referral
    ☐ Objective Testing (e.g. Beck Depression Inventory)
☐ Requires RBHA Referral if the child is < 8 years

Anxiety

☐ Completed Differential Diagnosis
  ☐ Objective Testing (e.g. Anxiety Self and Parent Tests)
☐ Requires RBHA Referral if the child is < 8 years
Updates Regarding Developmental and Behavioral Health Screenings by the PCP: Use of the PEDS Tool, ASQ, and M-CHAT R/F

By: Dr. Susan Stephens CMDP Medical Director

AHCCCS approved developmental screening tools (Parent’s Evaluation of Developmental Status (PEDS) Tool, Ages and Stages Questionnaire (ASQ), and Modified Checklist for Autism in Toddlers (M-CHAT R/F) should be utilized for developmental screening by all participating Primary Care Providers (PCPs) who care for Arizona Health Care Cost Containment System (AHCCCS) members, age 0 through 20 years. PCPs must be trained in the use and scoring of the developmental screening tools, as indicated by the American Academy of Pediatrics. The developmental screening should be completed for AHCCCS children during the Early, Periodic Screening, Diagnostic, and Treatment (EPSDT) visits. A copy of the screening tool must be kept in the medical record. Use of AHCCCS approved developmental screening tools may be billed separately using Current Procedural Terminology (CPT)-4 code 96110, (Developmental screening, with interpretation and report, per standardized instrumentation), with the EP modifier.

The Arizona Chapter of the American Academy of Pediatrics will be “approving” the certified trainings. They will be communicating which opportunities are approved to the association of AHCCCS health plans. They are currently looking at options for what online educational opportunities should “count” as certified for PEDS, ASQ and M-CHAT R/F.

How you can get certified NOW:

- You can become certified for the PEDS Tool today through American Academy of Pediatrics- Arizona Chapter (AzAAP). You just have to watch a presentation and complete a posttest online: http://azpediaclearning.org/test1.asp. AHCCCS is automatically made aware of your certification.

- You can become certified for new revised M-CHAT R/F by participating in one of Southwest Autism Research & Resource Center (SARRC) trainings. Sharman Ober-Reynolds, RN, PNP provides monthly free trainings. Phone: (602) 340-8717, Fax: (602) 340-8720, Email: sarrc@autismcenter.org They are able to travel outside Maricopa County for an additional fee.

- If you participate in any training for ASQ, PEDS or M-CHAT sponsored by the American Academy of Pediatrics or the American Academy of Family Physicians (either online or at a live conference), your certificate of attendance in that activity will “count” as you being certified.

Information about the various trainings will be posted on the Arizona Department of Health Services (AzDHS) website on a special Clinician’s page link. Providers will be instructed to print off a certificate once they complete the training and fax it to the centralized credentialing agency that all AHCCCS Health Plans are using. The form for this agency, Council for Affordable Quality Healthcare (CAQH) will be provided on the AzDHS website. CAQH will then store this information, along with everything else they keep, for the credentialing and recredentialing of AHCCCS providers. NOTE: New providers will be asked to indicate completed training on the AzAHP data form as well as uploading the certificate to CAQH as they begin the credentialing process with the AHCCCS Health Plan Credentialing Alliance.

Due to the at-risk nature of the population, CMDP reimburses for screenings done on all age-appropriate children, not just those at the 9- month, 18-month and 24-month visits.
Cultural Competency Pointers

What Is Cultural Competency?

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Adapted from Cross, 1989).

And why is it important?

Cultural competency is one the main ingredients in closing the disparities gap in health care. It’s the way patients and doctors can come together and talk about health concerns without cultural differences hindering the conversation, but enhancing it. Quite simply, health care services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients can help bring about positive health outcomes.

Culture and language may influence:

- health, healing, and wellness belief systems;
- how illness, disease, and their causes are perceived; both by the patient/consumer and the behaviors of patients/consumers who are seeking health care and their attitudes toward health care providers; as well as the delivery of services by the provider who looks at the world through his or her own limited set of values, which can compromise access for patients from other cultures.


Language Line

Language Line Services are provided for members and foster caregivers to communicate with CMDP and healthcare providers. The service is for interpretation in over 140 languages either by phone or written translation. American Sign Language is also available to help members and foster caregivers communicate with healthcare providers. We ask that you contact us one week in advance to arrange for language interpretation services. To request these services, you must contact CMDP Member Services at 602-351-2245 or 1-800-201-1795.
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 602-364-3976; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. • Disponible en español en línea o en la oficina 602-351-2245 o al 1-800-201-1795.

**Department Email Addresses**

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**Arizona Department of Child Safety**

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