

DEPARTMENT OF ECONOMIC SECURITY

DIVISION OF DEVELOPMENTAL DISABILITIES

**DEVELOPMENTALLY DISABLED/ARIZONA LONG
TERM CARE SYSTEM
(DD/ALTCS)**

FEE-FOR-SERVICE PROVIDER MANUAL

September 2008

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Contacting Us

Health Care Services (HCS), a unit of the Division of Developmental Disabilities (DDD), is responsible to coordinate the acute care services for persons with developmental disabilities who are enrolled in the Arizona Long Term Care System (ALTCS). We appreciate your assistance in the delivery of these acute medical services.

Our staff want to communicate with you to ensure that you understand what services are covered, which services require authorization, and how to be reimbursed for services you provide. If you have any questions, please call, write, or fax us at the following numbers:

Health Care Services 2200 N. Central Ave., Suite 207 & 506 Phoenix, Arizona 85004-1420	602/238-9028 phone 602/238-9294 Fax
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Medical Director Robert Klaehn, M.D.	602/542-6826 phone 602/364-1322 Fax
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Introduction to the Division of Developmental Disabilities

Introduction to this Manual

This Provider Manual is intended for health care providers delivering services to persons eligible for services from both the Division of Developmental Disabilities and the Arizona Long Term Care System. More information about these federal and state funded programs is in the next section.

In particular, this Manual is intended to explain the services covered, which services require prior authorization, and how to be reimbursed for services rendered to persons who are eligible for services but not enrolled in a Division subcontracted health plan. The list of **covered services**, found in the section titled Covered Services, explains the service and indicates whether **prior authorization** is required from Division personnel. **Claims submission** requirements are outlined in the section titled Claims.

If you have any questions about the contents of the Manual, or want a replacement copy, please contact the Provider Relations telephone number(s) listed on the Contacting Us page in the front of the Manual.

Organization and Funding

The Department of Economic Security (DES) is a social service agency of the Arizona State government. The Division of Developmental Disabilities (DDD), a sub-unit of DES, exists to advocate for and provide services to persons with developmental disabilities.

This Provider Manual is addressed to providers of health care services to persons whom the Division serves. The Manual will describe

- what services are covered,
- how to be reimbursed for service delivery, and
- how to contact staff of DES/DDD.

Funding for covered health care services comes from both the federal government (Medicaid) and the state of Arizona. The Arizona Health Care Cost Containment System Administration (AHCCCSA) funnels federal funds from the Centers for Medicare and Medicaid Services (CMS) to DES/DDD for persons and services covered under Medicaid.

AHCCCSA administers two health care programs: one, the Arizona Health Care Cost Containment System (AHCCCS), is for persons who need ambulatory health care services; and the second, the Arizona Long Term Care System (ALTCS), is for persons who are at risk for institutionalization due to their need for services. AHCCCSA contracts with DES/DDD to provide services to persons who qualify for DDD and

ALTCS services. ALTCS covers a mix of acute care, long term care and behavioral health services. DES/DDD uses state funds in conjunction with federal funds to provide these services.

The **acute care** services (e.g., physician office visits, prescriptions, lab and x-ray services, hospital admissions, medically necessary transportation) are coordinated through the office of Health Care Services (HCS). Staff of HCS include nurses who perform utilization review and quality improvement activities, and support staff who verify member eligibility and enrollment and work with provider offices to answer any questions.

ALTCS **long term care** services (e.g., personal attendant care, habilitative therapy, or respite care) are coordinated by the DDD Districts. DDD is a statewide program, serving persons with developmental disabilities in all fifteen Arizona counties. The state is divided into six (6) Districts to facilitate local communication with residents in all counties. District staff include Support Coordinators (also called Case Managers) who are responsible to ensure eligible persons receive the services for which they qualify, and nurses who can authorize needed care in the home setting and/or coordinate medical care needed in hospital or nursing facilities. The District staff are responsible to contract with providers of long term care services, as well as authorize and coordinate these services.

Background and Philosophy

DES/DDD believes in the principles of individual dignity, respect and self-direction for all persons with developmental disabilities. The goal of DES/DDD is to assist persons to grow, develop and achieve their unique potential. DES/DDD recognizes that the family is the primary caregiver for the person with developmental disabilities and should be consulted and involved in all care and service decisions. It is the role of DES/DDD and its providers to assist persons with developmental disabilities and their families in exercising their rights by adopting and implementing these principles and philosophy in the delivery of services. DES/DDD requires providers to take affirmative action to ensure that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference or physical or mental handicap.

Qualifying for DD/ALTCS Membership

Persons with developmental disabilities are eligible for certain services provided through the Department of Economic Security, Division of Developmental Disabilities (DES/DDD). ARS Section 36-551 and the DES/DDD Policy and Procedures Manual define developmental disability as a severe chronic disability which:

Is attributable to:

- Cognitive Disability
- Cerebral palsy
- Epilepsy
- Autism
- Developmental delay (age 0-5 years)

Is manifested before the person attains age eighteen (18) years;
Without appropriate intervention, is likely to continue indefinitely;
Results in substantial functional limitations in three or more of the following areas of major life activity:

- Self care
- Receptive and expressive language
- Learning
- Mobility
- Self-direction
- Capacity for independent living, and
- Economic self-sufficiency; and

Reflects the need for a combination and sequence of individually planned or coordinated special, interdisciplinary or generic care, treatment or other services, which are of lifelong or extended duration.

DES/DDD determines the person's eligibility for DES/DDD programs based on documentation of the above criteria. All individuals determined by the Division to meet the above criteria are eligible to receive long term care services from DES/DDD. AHCCCS determines which of these individuals are eligible for the ALTCS program.

DES/DDD has been providing ALTCS services since 12/19/88. Delivery of the long term care benefits is coordinated by DES/DDD personnel in the six DES/DDD Districts statewide. To deliver the ALTCS acute medical benefits, DES/DDD contracts with ambulatory health plans serving all fifteen Arizona counties. Most persons eligible for ALTCS and DDD services receive acute medical services through a subcontracted health plan; however, some members are not enrolled in a health plan. ALTCS members not enrolled with a health plan are eligible to receive covered services from the fee-for-service (FFS) providers to whom this Manual is addressed.

ALTCS Eligibility Determinations and Enrollment Specifications

AHCCCSA determines the person's eligibility for ALTCS based on financial criteria and an assessment of the person's functional, medical, nursing, and social needs. Financial eligibility is defined in ALTCS Rules and includes income guidelines for Supplemental Security Income (SSI) and Temporary Assistance to Needy Families (TANF).

All individuals determined to be eligible for ALTCS shall apply for any health or accident insurance benefits to which they are entitled. All insurance and other third party liability benefits shall be assigned and transferred to DES/DDD and AHCCCS (and by extension to the medical service provider) for covered services provided during the period of ALTCS eligibility.

ALTCS Medical Eligibility (Preadmission Screening)

AHCCCSA uses the Pre-admission Screening (PAS) process to assess medical eligibility. The PAS is used to determine if the individual is "at risk" of institutional placement in a nursing facility (NF) or intermediate care facility for the mentally retarded (ICF/MR).

PAS results are reported to DES/DDD, and are available to fee-for-service providers and subcontracted health plans. This information is the foundation for the member's service plan developed by DDD staff (see next paragraph regarding the ISP). If the person is not already eligible for DDD programs, DES/DDD then evaluates the person's needs and determines eligibility for services provided through DES/DDD.

For individuals meeting eligibility criteria, DES/DDD is required to provide case management data, including placement and the proposed Individual Support Plan (ISP) to AHCCCSA within thirty (30) days of enrollment with DES/DDD. If the proposed ISP includes services that require written authorization by the person's Primary Care Physician (PCP), DES/DDD Support Coordinators (formerly called Case Managers) will request input from the PCP to complete the proposed ISP.

The Division's Medical Care Program

The design of the Division's medical care program is very similar to that of AHCCCS. It is the Division's intention to contract with ambulatory health plans and fee-for-service providers to form a statewide network capable of delivering the highest quality medical services to persons with developmental disabilities. Administration of the Division's medical care program is provided through the Health Care Services (HCS) Unit. An organizational chart of the Unit is included in this Provider Manual (see Appendix A: HCS Table of Organization).

Providers of Health Care

Within the Division's medical care program, the PCP is the gatekeeper for medical services. The gatekeeper's function is to be the single provider coordinating the medical needs required for each of the Division's members. The PCP is responsible for administering medical treatment, for referring to other providers, and for monitoring the member's treatment throughout enrollment in the DD/ALTCS program. If DDD should develop any clinical practice guidelines specific to the DD/ALTCS program, these clinical practice guidelines will be sent directly to the fee-for-service provider. Selected evidence-based guidelines, such as those found at the Agency for HealthCare Research and Quality website, <http://ahrq.gov/>, are used to monitor and improve the quality of care provided.

Peer Review

DES/DDD maintains a process to review alleged inappropriate care, substandard care or inappropriate behavior by a provider. This process, including the appeals process, is described in the Peer Review policy in appendix J. All peer review information is confidential.

Contracted Health Plans and Special Services

It is the Division's intent to subcontract acute health care services to ambulatory health plans. The Division holds subcontracts with Arizona Physicians, IPA; Capstone Health

Plan, Inc.; Mercy Care Plan; and Care 1st Healthplan Arizona. These health plans are responsible for providing acute health care services to DD/ALTCS members throughout the State of Arizona. In counties or geographic service areas (GSAs) where contracted health plans provide the medical services, the Health Care Services Unit is responsible for providing technical assistance to the plans and for providing oversight of the delivery of service.

The Division also interacts with the Indian Health Service (IHS) and Children's Rehabilitative Services (CRS) to complement the Division's FFS and subcontracted health plans' provision of medical services. In addition, certain DD/ALTCS members eligible for behavioral health services may receive service through the Regional Behavioral Health Authority (RBHA). The RBHA is an organization under contract with the Arizona Department of Health Services to administer the provision of covered behavioral health services in a geographically specific service area of the state to eligible members, including DD/ALTCS eligible members.

Members Served on a Fee-For-Service Basis

The goal of the Health Care Services Unit is to provide high quality, cost effective medical care in a manner that is sensitive to the individual member's needs. In the event that a specific county or geographic service area (GSA) does not have an available subcontracted health plan to provide services, the Division will contract with individual health care providers on a fee-for-service (FFS) basis. FFS providers are not required to contract with the Division to render services to eligible persons; however, each provider must be registered with AHCCCS and have a National Provider Identification Number (NPI).

The Unit is responsible for provider recruitment and contracting. The Unit also operates as a health plan in the areas of prior authorization, referral, EPSDT coordination, claims processing, quality management/utilization review and risk management.

Regardless of member enrollment with a subcontracted health plan or a FFS Provider, the Health Care Services Unit, through its Member Services and Provider Relations staff, also assists members in accessing services and works with contracted providers to implement the delivery of quality care.

The Provider Relations Unit currently has representatives located in Phoenix and Flagstaff who provide training and consultation throughout the state. They are available Monday through Friday from 8:00am to 5:00pm. Providers can reach a Provider Relations staff member in Phoenix by calling 1-602-238-9028, ext. 6025 or ext. 6026. Provider Relations staff may be reached in Flagstaff by calling 1-928-773-4957, ext. 2222. (See Contacting Us in the front of this Provider Manual for HCS Provider Relations staff contacts, and Appendix A for Provider Relations Geographic Assignments Map.)

Provider Registration

The FFS Provider must be registered with AHCCCSA as an approved service provider. Possession of a National Provider Identification Number (NPI) is required for a provider to be paid through the Division.

The FFS Provider must also have on file with DES/DDD a current W-9 form (Request for Taxpayer Identification Number and Certification). If the provider's name, tax ID number, or address changes, a new W-9 must be completed and forwarded to your Provider Relations Representative.

The Division's Health Care and Monitoring System

The purpose of the Health Care and Monitoring system is to augment the medical care program delivered through either subcontracted health plans or FFS Providers. The system may include, but is not limited to:

- Community nursing (periodic assessment and planning)
- Skilled nursing services (assessment, planning, intervention, collaboration and intermittent care)
- Discharge planning from acute care settings
- Team case management, including a R.N. for ventilator dependent members
- Nursing consultation

The provision and availability of the Division's health care planning and monitoring system varies from county to county, depending on resources and staff available. It is expected that appropriate understanding and collaboration among providers will reduce the overall utilization of medical services. The Division's health monitoring system staff want to work with you, the provider. To contact nursing personnel in your area, call the person listed in your county (see Appendix B: District Nurse Contacts).

PCP Assignment

DD/ALTCS members who are not enrolled in a subcontracted health plan will be assigned to a primary care physician (PCP) who agrees to work with DES/DDD. The member will be given the opportunity to choose his/her PCP. Failing a timely choice, the member will be assigned to the PCP with an office closest to the member's residence.

Members may change PCPs by calling the HCS Member Services Representative. Members will be encouraged to develop a workable patient/physician relationship to ensure continuity of care; however, if the member wants to change PCPs, the new choice

will be honored. If the Member Services Representative notices that a member has changed PCPs multiple times, s/he will contact the member's Support Coordinator to develop an action plan to encourage the member to develop a workable patient/physician relationship.

PCPs may request that a member not be assigned to him/her. Call your Provider Relations Representative to discuss such a request. Difficult members must continue to be provided services. (See **Difficult Member Arrangements in the PCP section** of this Manual.)

Verification of DD/ALTCS Eligibility

HCS distributes an ID card to FFS members, which identifies DES/DDD as the health care provider. For members assigned to a subcontracted health plan, the subcontracted health plan distributes a health plan ID card to the member. Members are asked to present the health plan ID card whenever they access medical care (in PCP's and specialist's offices, at laboratories, pharmacies, hospitals, emergency rooms, etc.).

Eligibility can be verified by calling the DDD Member Services Representative at (602) 238-9028 (Monday through Friday, 8:00am - 5:00pm) or at 1-800-624-4964 (24 hours per day/7 days per week). Prior authorization must be obtained from the appropriate staff (either health plan or HCS) and claims submitted to the appropriate party. Ask the member to show their ID card to verify this.

Other Medical Insurance

DD/ALTCS members may also have other medical insurance coverage. Members and responsible persons are asked to inform medical care providers of all available medical insurance, including Medicare and private insurance. Providers should inquire about insurance coverage at the first contact with the member and should update insurance information at the time of each office visit. FFS Providers are required to bill any other insurance, including Medicare prior to billing DES/DDD for any DD/ALTCS (Medicaid) covered service. (See **Provider Reimbursement for Services** in this Manual.)

Co-Payments

DD/ALTCS members are not required to pay co-payments.

For example, well-child visits and prenatal care visits do not have co-payments, and there are no co-payments for lab, x-ray, pharmacy, or office visits.

Interpreter Services

Interpreter services are available for DES/DDD fee-for-service providers. To schedule interpreter services, please contact the member's DDD Support Coordinator. If you do not know the name and telephone number of the member's Support Coordinator, contact your Provider Relations Representative or Member Services at 602/238-9028, extension

6029. You will need to provide the member's name, date of birth and ID number when calling.

Provider Reimbursement for Services

All claims for covered services should first be sent to applicable third party payers (including Medicare and private insurance companies). If complete payment is not made by other insurance, the claim accompanied by the other insurance Explanation of Benefits, should be submitted to:

DES/Division of Developmental Disabilities
Business Operations/Acute Care Claims Unit
1789 West Jefferson, Site Code 791A
P.O. Box 6123
Phoenix, Arizona 85005

Capped Fee For Service Schedule

Approved services are reimbursed according to the AHCCCS Capped Fee-For-Service Schedule (CFFS). You may request a copy of the CFFS by calling the Provider Relations staff in your area. In this Manual, CFFS refers to all AHCCCS mandated fee schedules for provider reimbursement, including the fee-for-service schedule for outpatient, non-hospital charges; hospital per diem and cost-to-charge ratios; and the maximum allowable cost for pharmacy claims. DES/DDD reimburses all hospitals in Maricopa and Pima counties at the AHCCCS mandated hospital reimbursement rate, regardless of the county of residence of the member admitted to the facility.

Claims Submission

The PCP and other service providers must submit claims on the standard forms mandated by AHCCCS and CMS (Center for Medicare and Medicaid Services) – formerly HCFA (Health Care Financing Administration):

- Form CMS 1500 must be submitted for professional services, transportation, and durable medical equipment.
- Form UB04 must be submitted for inpatient hospital services, outpatient, emergency room, and hospital-based clinic charges and pharmacy charges for services provided as an integral part of a hospital service. Additionally, the UB04 is used to bill for dialysis clinic, nursing home, free standing birthing center, residential treatment center, and hospice services.
- ADA Form for dental claims.

All claims must include the National Provider Identification Number (NPI) and AHCCCS coded categories of service assigned to the billing provider. Verification of your NPI number and approved categories of service may be obtained by calling

AHCCCS, Provider Services, at (602) 417-7670, option #5. The in-state toll free number is 1-800-794-6862. The out-of-state toll free number is 1-800-523-0231. Submittal of incomplete claims will result in a denial of payment.

Payment on UB04 claims will be made by the Division within 30 days of receipt of a clean claim. The reimbursement amount will be according to the AHCCCS hospital charge calculation. Payment on CMS 1500s and ADA Forms will be within 30 days of receipt of a clean claim. The reimbursement amount will be according to the applicable AHCCCS Capped Fee-For-Service Schedule.

Claim Submission Deadlines

Claims must be originally submitted within six (6) months of the Date of Service (DOS), and reach clean claim status within twelve months of the DOS. Claims not meeting these deadlines will be denied.

Claim Reference Number (CRN)

A Claim Reference Number (CRN) is assigned to all claims on each submission to DES/DDD. The first five characters of the CRN represent the Julian date the claim was received by DES/DDD. The remaining numbers make up the claim document number assigned by DES/DDD. A new CRN is assigned to a claim when it is resubmitted or adjusted.

Claims Completion Instructions

UB-04

The following instructions for completion of the UB04 claim form should be used to supplement the information in the AHA Uniform Billing Manual for the UB04

Note: All **bold type** fields are required by DES/DDD. Failure to complete these fields may cause the claim to be denied. An asterisk (*) next to the number of a bold (required) field indicates required if applicable.

Field	Name/Status	Instructions
1.	Provider Data	Provider’s name, address, and phone number.
2.	Pay –To-Name and Address	The address that the provider submitting the bill intends payment to be sent if different than that of the Billing Provider (See #1)
3.a	Patient Control No.	Account or bill control number assigned by provider. DES/DDD will return this number as a cross reference on Remittance Advice.
3.b*	Medical/Health Record Number	This is the number assigned to the patient’s medical/health record by the provider.

Field	Name/Status	Instructions
4.	Bill Type	Facility type (1st digit), bill classification (2nd digit), and frequency (3rd digit). See UB04 Manual for codes.
5.	Fed Tax No.	Federal tax identification number.
6.	Statement Covers Period	Beginning and ending dates of billing period in MM/DD/YY format.
7.	Reserved	Not currently in use.
8.a-e	Patient Name/ Identifier	Last name, first name and middle initial of the patient and the patient identifier as assigned by payer.
9.*	Patient Address	The mailing address of the patient.
10.*	Patient Birth Date	
11.	Patient Sex	
12.	Admission/Start of Care Date	The start date for this episode of care. For inpatient services, this is the date of admission. For other services, it is the date the episode of care began.
13.*	Admission Hour	The code referring to the hour during which the patient was admitted for inpatient or outpatient care.
14.	Priority (Type) of Visit (Inpatient only)	A code indicating the priority of the admission/visit. See UB-04 Manual for codes.
15.	Source of Referral for Admission or Visit (Inpatient only)	A code indicating the source of the referral for this admission or visit. See UB-04 Manual for codes.
16.	Discharge Hour (Inpatient Only)	Code indicating discharge hour of the patient from <i>inpatient care</i> . Required if applicable.
17.	Patient Discharge Status (Inpatient Only)	A code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill. See UB-04 Manual for codes.
18-28.	Condition Codes:	A code(s) used to identify conditions or events relating to this bill that may affect precessing. See UB-04 Manual. Required for inpatient and outpatient claims. See UB-04 Manual for hour codes.

Field Name/Status	Instructions
29* Accident State	The accident state field contains the two-digit state abbreviation where the accident occurred. Required when the services reported on this claim are related to an auto accident and the accident occurred in a country or location that has a state, province, or sub-country code. See UB-04 Manual for codes. Required if applicable.
30. Reserved	Not currently in use.
31-34* Occurrence Codes and Dates	The code and associated date defining a significant event relating to this bill that may affect payer processing. See UB-04 Manual for codes.
35-36* Occurrence Spans Codes and Dates	A code or related dates that identify an event that relates to the payment of the claim. See UB-04 Manual for codes.
37. Reserved	Not currently used.
38* Responsible Party Name and Address	Responsible party name and address. The name and address of the party responsible for the bill.
39-41* Value Codes and Amounts	A code structure to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization. See UB-04 Manual for codes.
42. Revenue Codes	Codes that identify specific accommodation, ancillary service or unique billing calculations or arrangements. See Revenue Code categories are four digits. See UB-04 Manual for codes.
43. Revenue Code Description	Refer to the UB-04 Manual for description of revenue codes.
44. HCPCS/Rates/ Accommodation Rates	Enter accommodation rate for inpatient bills and HCPCS code for all applicable ancillary services on outpatient bills. HCPCS codes are required for certain outpatient revenue codes.
45* Service Date (outpatient)	Enter the date (MMDDYY) the outpatient service was provided.
46. Service Units	If accommodation days are billed, number of units billed, or for items such as dialysis treatments, pints of blood, etc.
47. Total Charges	Total charges obtained by multiplying units of service by

Field	Name/Status	Instructions
		unit charge for each revenue code. Each line other than sum of all charges may include charges up to \$999,999.99.
48.*	Non-Covered Charges	Enter any charges which are not payable by DES/DDD. Last entry in Field 48 is total non-covered charges, represented by revenue code 001.
49.	Reserved	Not required.
50.* (A-C)	Payer Name	Enter name and identification number, if available, of each payer who may have full or partial responsibility for the charges incurred by recipient and from which provider might expect some reimbursement. DES/DDD should be last entry.
51.	Health Plan ID#	This is a number used by the health plan to identify itself in Field 50 A,B, and/or C. AHCCCS Provider ID should be listed last.
52. (A-C)	Release of Information	Enter "Y" if provider has signed, written consent from recipient to release medical/billing information. Otherwise, enter "R" for restricted (or modified) release or "N" for no release.
53.	Assignment of Benefits Certification Indicator	Required.
54.* (A-C)	Prior Payments	Enter amount received from any payer other than DES/DDD, including patient, listed in Field 50. If no payment was received as a result of billing, enter "0". (The "0" indicates that a reasonable attempt was made to determine available coverage for services provided. Enter the only actual payments received. Do not enter any amounts expected from DES/DDD.)
55. (A-C)	Estimated Amount Due	The amount estimated by the provider to be due from the indicated payer.
56.	National Provider Identifier (NPI)	Required
57.a	Other (Billing) Provider Identifier	Required if applicable Enters AHCCCS # for atypical providers.
58.	Insured's Name	Enter name of insured covered by payer in Field 50.

Field	Name/Status	Instructions
59.	Patient's Relationship (A-C)	Enter relationship of recipient to insured. to insured.
60.	Insured's Unique Identifier (AHCCSID)	The unique number assigned to the Health Plan to the insured. Required.
61.	Insured's Group Name	Enter insured's group name or "FFS" for AHCCCS or ALTCS recipients not enrolled in a plan.
62.	Insurance Group Number	Leave blank for Fee-For-Service recipients.
63.	Treatment Authorization Code	The PA number should be entered in this field. The DES/DDD system will search PA files to locate and associate valid PA with the claim
64.	Document Control Number (DCN)	A control # number assigned to the original bill.
65.	Employer Name	Enter name of insured's employer.
66.	Diagnosis and Procedure Code Qualifier (ICD)	The qualifier that denotes the version of International Classification of Diseases (ICD) reported.
67.a-q	Principal Diagnosis and Other Diagnosis Codes	Enter principal ICD-9 diagnosis code. (Code should match diagnosis code listed on DES/DDD Prior Authorization if obtained.)
68.		Reserved Not currently used.
69.	Admitting Diagnosis	Required for inpatient bills. Enter ICD-9 diagnosis code that represents significant admitting diagnosis.
70.	a-c Patient's Reason for Visit (Outpatient Only).	
71.	Prospective Payment System (PPS) Code	
72*	a-c External Cause of Injury (ECI) Code	The ICD-9 diagnosis codes pertaining to external cause of injuries, poisoning, or adverse effect.
73.	Reserved	Currently not used.

Field	Name/Status	Instructions
74.a-e	Principal and Other Procedure Codes and Dates	Required on INPATIENT claim when a procedure was performed. Not required on outpatient claims. Enter the ICD-9 code that identifies the inpatient procedure performed. Enter date as MMDDYY.
75.	Reserved	Currently not used.
76.*	Attending Provider Name and Identifier (NPI)	
77*.	Operating Physician Name and Identifier (NPI)	The name and identification number of the individual with the primary responsibility for performing surgical procedures. Required if surgical code is listed on claim.
78.-79	Other Provider (individual)	Name and Identifiers (NPI).
80*	Remarks Field	Enter the Claims and Reference Number (CRN) assigned to the original bill. Required when a claim is a replacement or void to a previously adjudicated claim and the Bill Type indicates a void or replacement.
81*	Code	Code Field to report additional codes related to a Form Locator (overflow) or to report externally maintained codes approved by NUBC. See UB04 Manual.

CMS 1500 Claim Form Instructions

The following instructions apply for completing the CMS 1500 claim form.

Note: All **bold type** fields are required by DES/DDD. Failure to complete these fields may cause the claim to be denied. An asterisk (*) next to the number of a bold (required) field indicates required if applicable.

Field	Name/Status	Instructions
1.	Program Block	Check second box labeled “Medicaid”.
1a.	Insured’s ID Number	Enter recipient’s HCS ID number. If there are questions about eligibility of the HCS ID number, call DES/DDD Member Services.
2.	Patient Name	Enter recipient’s last name, first name, and middle initial as they appear on the HCS ID card.
3.	Patient Birth Date and Sex	Enter recipient’s date of birth and Sex. Check appropriate box to indicate patient’s gender.
4.	Insured’s Name	Enter “Same” to indicate that insured and recipient name in Field 2 are same.
5.	Patient Address	Enter recipient’s address as street, city, state, and zip code. Enter area code and telephone number.
6.	Patient Relation to Insured	Not required.
7.	Insured Address	Not required.
8.	Patient Status	Check boxes that represent recipient’s marital status, employment, and student status.
9.*	Other Insured’s Name	If recipient has no coverage other than ALTCS, leave blank. If other coverage exists, such as private insurance, enter name of insured. If other insured is recipient, enter “same” to indicate that other insured’s name is the same as recipient.
9a.*	Other Insured’s Group Number	Enter group number of other insurance.
9b.	Other Insured’s DOB/Sex	If the other insured is not the ALTCS recipient, complete this block.

Field	Name/Status	Instructions
9c.	Other Insured's Employer/School	Enter name of organization through which insurance is obtained, such as employer of insured or school that makes insurance available.
9d.*	Insurance Plan or Program Name	Enter name of insurance company or program name that provides the insurance coverage.
10.* (A-C)	Relation of Patient Condition	Check appropriate box to indicate if recipient's condition is result of employment, auto accident, or other type of accident.
10d.	Reserved	Not currently in use.
11.	Insured's Group Policy or FECA #	If recipient is a newborn, enter mother's HCS ID number.
11a.	Insured's DOB/Sex	Not required.
11b.	Employer's Name or School Name	Not required.
11c.	Insurance Plan Name or Program Name	Not required.
11d.*	Other Health Benefit	Check appropriate box to indicate other health benefit.
12.	Patient or Authorized Person's Signature	Recipient's signature will authorize release of medical or treatment data.
13.	Insured's/Authorized Person's Signature	Not required.
14.*	Date of Illness or Injury	Enter date of onset of symptoms or date of injury, if available.
15.	Date of Same or Similar Illness	Not required.
16.	Dates Patient Unable to Work in Current Occupation	Not required.
17.*	Name of Referring Physician	If recipient was referred or service was ordered by another physician, enter name of referring physician. If the service billed was not a referral, enter "0".

Field	Name/Status	Instructions
17a.	ID of Referring Provider	(Required only for podiatry services.)
17b.	NPI of Referring Provider (shaded area)	(Required only for podiatry services)
18.	Hospitalization Dates	For hospitalized recipients, enter From and Through dates of hospitalization related to service billed on this claim.
19.	Reserved for Local Use	Not required.
20.	Outside Lab	Check appropriate box to indicate whether outside lab work was performed as part of service. If “Yes” is checked, enter charge for these services.
21.	Diagnosis Codes	Enter up to four ICD-9 diagnosis codes appropriate to recipient’s condition. Only ICD-9 codes will be accepted. Written description is optional.
22.*	Medicaid Resubmission Code	<p>Enter appropriate code to indicate whether claim is an adjustment or void of paid claim or resubmission of denied claim:</p> <p>A Adjustment of paid claim V Void of paid claim R Resubmission of denied claim.</p> <p>For adjustments, enter “A”. All claim lines must be submitted for reprocessing. Make changes to appropriate lines and submit entire claim for reprocessing. Do not blank out any lines. If any lines are blanked out, system will assume that line should not be considered for reimbursement and will recoup that line when the claim is reprocessed.</p> <p>For voids, enter “V”. Submit only those claim lines to be voided.</p> <p>For resubmissions, enter “R”. All claim lines must be submitted for reprocessing. Make necessary changes to appropriate lines and submit entire claim for reprocessing. Do not blank out any lines of the 1500. If any lines are blanked out, the system will assume that those lines should not be considered for reimbursement.</p>

<u>Field Name/Status</u>	<u>Instructions</u>
	Claims to be voided or adjusted must have been paid by DES/DDD. Claim resubmissions must have been denied by DES/DDD.
23. Prior Authorization Number	The DES/DDD claims system will search for a valid prior authorization for the claim. Providers must still request PA, as appropriate, from the HCS PA Unit. The claim must match the PA number assigned by the HCS PA Unit.
24A. Date of Service	Enter beginning and ending service dates as MM/DD/YY. If service was completed in one day, dates will be the same. From date must be equal to or prior to the To date. To date must be equal to or prior to billing date (Field 31).
24B. Place of Service	Enter the code that describes the place of service: 11 Office 12 Patient's residence 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room - hospital 24 Ambulatory surgical center 25 Birthing Center 26 Military treatment facility 31 Skilled nursing facility 32 Nursing facility 33 Custodial care facility 34 Hospice 41 Ambulance - land 42 Ambulance - air or water 51 Inpatient psychiatric facility 52 Psychiatric facility partial hospitalization 53 Community mental health center 54 Intermediate care facility/mentally retarded (ICF/MR) 55 Residential substance abuse treatment facility 61 Comprehensive inpatient rehabilitation facility 62 Comprehensive outpatient rehabilitation facility 65 End stage renal disease treatment facility 71 State or local public health clinic 72 Rural health clinic 81 Independent laboratory 99 Other unlisted facility Note: Non-emergency transportation providers should use "99".

<u>Field Name/Status</u>	<u>Instructions</u>
24C*. EMG – Emergency Indicator	Mark this box if service was an emergency service, regardless of where it was provided. Indicate emergency on each line applicable. Documentation attached to the claim to substantiate the emergent nature of the service will not be reviewed if service is not indicated as an emergency.
24D. Procedure, Services Or Supplies	Enter HCPCS/CPT procedure code that identifies the service provided. Enter procedure modifier if appropriate.
24E. Diagnosis	Relate service provided to diagnosis in Field 21 by entering number of diagnosis. Enter only reference to Field 21 (1-4), not diagnosis code itself. If more than one number is entered, they should be in descending order of importance.
24F. Charges	Enter total charges for each procedure. If more than one unit of service was provided, enter charges for all units. For example, if each unit is billed at \$50.00 and three units were provided, enter \$150.00 here and three units in Field 24G.
24G. Units	Enter units of service provided during dates in Field 24A. Unit definitions must be consistent with HCPCS Manual. Bill all units of service delivered on given date on one line.
24H. EPSDT/ Family Planning	If the service billed on this line is an EPSDT service, result of an EPSDT referral, or a family planning service, enter the appropriate code in this field.
24I* ID Qualifier.	
24J.* COB (Shaded Area)	Use the shaded field to report the coordination of benefits. This field is used to report benefits for recipients with Medicare and/or other insurance. Enter Medicare Coinsurance and Deductible amounts. First amount will always be considered Coinsurance and second amount will be treated as Deductible. If there is no Deductible, enter Coinsurance amount/zero (Example: \$20/0). For recipients and services covered by third party payer, enter amount paid. Attach EOB. Enter the Rendering Provider NPI in the non-shaded area.

Field	Name/Status	Instructions
25.	Federal Tax ID	Required.
26.	Patient's Account Number	Enter any number as a patient account number that identifies this claim uniquely. DES/DDD will report this number on the remittance advice, providing a cross reference between DES/DDD CRN and provider's own accounting or tracking system.
27.	Accept Assignment	Not required.
28.	Total Charges	Enter total for all charges for all lines on claim.
29.*	Amount Paid	Enter total amount provider has been paid for claim by all sources other than DES/DDD. Do not enter any amounts expected to be paid by DES/DDD.
30.	Balance Due	Enter balance due by subtracting sum of payments in Field 29 from total charges.
31.	Signature	Claim must be signed by provider or authorized representative. Rubber stamp signatures are acceptable if initialed by provider representative.
	Date	Enter date on which claim was signed.
32.	Name and Address of Facility Where Services Were Rendered	Required.
32*a.	Service Facility	Enter the Service Facility NPI# (non-shaded area)
32*b.	Service Facility	Enter the Service Facility NPI#
33.	Provider Name, Address and Phone	Enter name, address, and telephone number of provider rendering service. If a group is billing, enter group biller's name, address and telephone number.
33*a.	Billing Provider NPI (non-shaded area)	Enter service provider's six- digit AHCCCS provider ID number and two-digit locator code next to the "PIN#". Do not enter more than two digits for locator code.
33*b.	Other ID	AHCCCS ID# (shaded area). If the service provider is part of a group recognized by AHCCCS and wishes payment to be made to the group, the group ID number should be entered in "GRP#" field.

Note

NPI is required for all providers that are mandated to maintain a NPI number.

ADA Form Instructions

The ADA 2002 claim form is the only form that DES/DDD will accept for billing dental services provided on or after January 1, 2004.

The following instructions apply for completing the ADA claim form:

Note: All **bold type** fields are required by DES/DDD. Failure to complete these fields may cause the claim to be denied. An asterisk (*) next to the number of a bold (required) field indicates required if applicable.

Field Name/Status Instructions

- | | | |
|-----|--|--|
| 1. | Type of Transaction | Not required. |
| 2.* | Predetermination/
Preauthorization
Number | Enter appropriate code (“A” or “V” to indicate if claim is a resubmission of a denied claim, an adjustment of a paid claim, or a void of a paid claim. Enter the DDD Claim Reference Number (CRN) of the denied claim being submitted or paid claim being adjusted or voided in the Field labeled “Original Reference No.” |
| 3.* | Primary Payer
Name and Address | Required if applicable. |
| 4. | Other Dental or
Medical Coverage | Check appropriate box to indicate whether member has third party coverage |
| 5. | Subscriber name | Required if applicable. |
| 6. | Date of Birth | Required if applicable. |
| 7. | Gender | Required if applicable. |
| 8. | Subscriber Identifier | Required if applicable. |
| 9. | Plan/Group Number | Required if applicable. |
| 10. | Relationship to
Primary Subscriber | Required if applicable. |
| 11. | Other Carrier Name,
Address | Required if applicable. |
| 12. | Primary Subscriber
Name and Address | Enter the member’s last name, first name and middle initial. |
| 13. | Date of Birth | Enter member’s date of birth. |

Field	Name/Status	Instructions
14.	Gender	Check appropriate box indicating members' gender.
15.	Subscriber Identifier	Enter member's AHCCCS ID number. Contact the 24/7 800 number listed in "Contacting Us" if there are questions regarding eligibility or the AHCCCS ID number.
16.	Plan/Group Number	Not required.
17.	Employer Name	Not required.
18.	Relationship to Primary Subscriber	Not required.
19.	Student Status	Not required.
20.	Name	Not required.
21.	Date of Birth	Not required.
22.	Gender	Not required.
23.	Patient ID/ Account Number	This is your number, assigned to identify this claim in your records. This number will provide a cross-reference between the DES/DDD CRN and your own accounting or tracking system.
24.	Procedure date	Enter the procedure date in MM/DD/YYYY format.
25.	Area of Oral Cavity	Enter the code for the area of the oral cavity. Consult ANSI/ADA/ISO Specification No. 3950 <i>Designation System for Teeth and Areas of the Oral Cavity</i> for codes.
26.	Tooth System	Enter "JP" when designating teeth using the ADA's Universal/National Tooth Designation system. Enter "JO" when using ANSI/ADA/ISO Specification No. 3950.
27.	Tooth Number (s) or Letter (s)	Enter the tooth number when the procedure directly involves a tooth. Use commas to separate individual tooth numbers. If a range of teeth is involved, use a hyphen to separate the first and last tooth in the range.
28.	Tooth Surface	Designate tooth surface(s) when the procedure directly involves one or more tooth surfaces.
29.	Procedure Code	Enter the appropriate procedure code from the CDT-4 Manual.

Field	Name/Status	Instructions
30.	Description	Enter the description of the procedure code billed in Field 29.
31.	Fee	Enter the fee for the procedure code billed in Field 29.
32.	Other Fees	Not required.
33.	Total Fee	Enter the total of all fees in Field 31.
34.	Missing Teeth	Mark all missing teeth.
35.	Remarks	Not required.
36.	Parent/Guardian Signature and Date	Not required.
37.	Subscriber Signature And Date	Not required.
38.	Place of Treatment	Check the appropriate box.
39.	Number of Enclosures	Required if applicable.
40.	Is Treatment for Orthodontics?	Required if applicable.
41.	Date Appliance Placed	Required if applicable.
42.	Months of Treatment	Required if applicable.
43.	Replacement of Prosthesis	Check the appropriate box. If “Yes” is checked, complete Field 44.
44.	Date of Prior Placement	Required if applicable; If “Yes” is checked in Field 43, enter the date of prior placement in MM/DD/YYYY format.
45.	Treatment Resulting	Required if applicable; Check the appropriate box, as applicable.
46.	Date of Accident	Required if applicable; Enter the date in MM/DD/YYYY format.
47.	Auto Accident State	Required if applicable; Enter the name of the state where the accident occurred.

Field	Name/Status	Instructions
48.	Billing Dentist/ Dental Entity Name And Address	Enter the name and address of the billing dentist or dental entity.
49.	Provider ID (Group)	Enter the AHCCCS provider ID of the billing dentist or dental entity.
50.	License Number	Enter the license number of the billing dentist or dental entity.
51.	SSN or TIN	Enter the Social Security Number or tax ID number of the billing dentist or dental entity.
52.	Phone Number	Not required.
53.	Signature of Treating Dentist	The claim must be signed by the provider or his/her authorized representative. Rubber stamp signatures are acceptable if initialed by the provider representative. Enter the date on which the claim was signed.
54.	Provider ID (Group)	Enter the AHCCCS provider ID of the treating dentist.
55.	License Number	Enter the license number of the treating dentist.
56.	Address (Treating Dentist)	Not required.
57.	Phone Number (Treating Dentist)	Not required.
58.	Treating Provider Specialty	Not required.

Universal Pharmacy Claim Form Instructions

The Universal Pharmacy claim form is the only form that DES/DDD will accept for billing pharmacy items that are not an integral part of a hospitalization.

The following instructions apply for completing the Universal Pharmacy Form:

Note: All **bold type** fields are required by DES/DDD. Failure to complete these fields may cause the claim to be denied. An asterisk (*) next to the number of a bold (required) field indicates required if applicable.

Field	Name/Status	Instructions
1.	Group Number	Not required.
2.	Card Holder ID	Enter nine-digit AHCCCS ID of recipient for whom the prescription was written.
3.	Card Holder Name	Enter name of recipient for whom prescription was written.
4.	Other Third Party Coverage	Check appropriate box to indicate whether recipient has third party coverage.
5.	Patient Information	Enter recipient's last name, first name, and middle initial; date of birth, if available; sex; and relationship to the cardholder.
6.	Pharmacy Information	Enter name, street number, city, state and zip code of provider who filled prescription
7.	Pharmacy Number	Enter six-digit AHCCCS provider ID number and two-digit locator code assigned.
8.	Phone	Enter phone number, including area code, of pharmacy that filled prescription
9.	Date Rx Was Written	Enter date of prescription as MM/DD/YY.
10.	Date Rx Was Filled	Enter date of service for this billing. If prescription is a refill, date of refill should be entered.
11.	Rx Number	Enter the prescription number. This will serve as a cross reference with the DES/DDD CRN. Correspondence from DES/DDD regarding the claim will reference this number.
12.	New or Refill	Enter "N" if claim is new, "R" if it is a refill.
13.	Metric Quantity	Enter quantity provided. If form is tablets or capsules, number should be number of pills dispensed.

Field	Name/Status	Instructions
14.	Days Supply	Enter number of days prescription is expected to cover.
15.	National Drug Code	Enter labeler number, the product number, and package number for the items dispensed. All 11 digits must be entered on claim form. If there are leading zeros in NDC code, they must be entered. Example:
	Labeler No. 0000	Product No. 1234
		Pkg. 567
16.	Prescriber Ident.	Enter AHCCCS provider ID of the prescribing physician, if the number is available.
17.	DAW	Indicate whether prescribing provider required a brand name drug by entering "1". If generic items were allowed, enter "0".
18.	Ingredient Costs	Enter cost of ingredients of dispensed items to pharmacy.
19.	Dispensing Fee	Not required. Dispensing fee systematically added by DES/DDD system.
20.	Tax	Do not enter sales tax amounts. DES/DDD is exempt from payment of sales tax.
21.	Total Price	Enter sum of components' cost (not including dispensing fee).
22.*	Deductible Amount	Enter amount of any third party payments received. If third party payer was billed and claim was denied or no payment resulted, enter "0". The "0" indicates that a reasonable attempt was made to determine available coverage and collect for service provided.
23.	Balance	Enter amount due from DES/DDD (not including dispensing fee).
24.	Authorized Pharmacy Representative	Authorized representative of pharmacy must sign and date claim. Rubber stamp signatures acceptable but must be initialed by a provider representative.

Remittance Advice

Reimbursement checks are accompanied by a remittance advice (remit). The remit identifies the provider and provider ID number, the type of claim submitted (UB-04, CMS 1500, ADA, Universal C Form), the date of the check run, the member name, ID number, and patient account code (if the provider supplied this code on the claim form), the services claimed and dates of service, and DES/DDD's adjudication results. DES/DDD may pay, pend, or deny a claim.

Providers who disagree with the DES/DDD adjudication results may file a written request for review within 35 days of the date of the remit. Send this request for review to:

DES/DDD Business Operations
1789 W. Jefferson, Site Code 791A
P.O. Box 6123
Phoenix, Arizona 85005

Providers who have questions about the remit may call DES/DDD Business Operations during normal working hours at 542-6874.

How to Read a Remittance Advice

The remit fields are described below:

1. Provider ID number The AHCCCS Provider Registration Number

2. Provider Name, Address If the provider is listed as a member of a group, the group name and address will appear here. If the provider bills as an individual, the provider's name and address will appear here.

3. Type of Claim Either UB-04 or CMS 1500 or Pharmacy Claim will appear here, depending on the provider claim submission type.

4. Remit Date: The date the remittance advice report was run. Checks are mailed within 2 business days of this date. Provider requests for review are timed from this date.

5. Remit Headings Revenue Code means the revenue code submitted on the claim. The remit will list each revenue code in descending order, with associated amounts.

Amount billed means the amount the provider billed.

Not Allowed means the amount DES/DDD will not pay because it is over the CFFS amount.

Allowed amount means the billed amount minus the not allowed amount.

Other insurance means the amount paid by other insurance.

Co-pay amount means the amount the member is responsible to pay as a co-payment.

Discount/Interest means the amount DES/DDD can deduct from the payable amount due to AHCCCS rule or the amount of interest DES/DDD must pay for late payment according to AHCCCS rule.

Amount paid means the amount DES/DDD paid on this claim on this remit.

Remarks identifies the reason(s) for DES/DDD adjudication. Remarks apply to the revenue code/claim line identified.

- 6. Member name, ID number Member identifying information supplied on claim, rate code, and patient account number (if supplied by the provider)
- 7. CRN # Claim Reference Number assigned to the claim by DES/DDD.
- 8. Date(s) of service Date(s) of service on the claim.

The second page of the remit totals all revenue codes/claim lines into payment categories for the fiscal year. Payment category definitions are:

Amount billed	The amount billed on the provider claim
Not allowed	The amount DES/DDD cannot pay due to AHCCCS CFFS rule
Allowed amount	The amount billed minus the amount not allowed.
Other insurance	The amount paid by other insurance
Co-Payment	The amount due from the member
A - Advance Payment	The amount of any advance payments made to the provider by DES/DDD

B - Bonus	The amount of bonus payments made according to contract terms by DES/DDD
D - Discount/Interest	The amount of discount taken or interest applied according to AHCCCS rule
W - Withhold	The amount from the claim(s) that DES/DDD has withheld from provider payments according to contract terms
Amount Paid	The total amount paid to the provider by DES/DDD during the fiscal year.

Page 3 of the remit details provider total payments by payment categories as above.

Page 4 of the remit details provider total payments by claim type (i.e., out-patient, in-patient, or Rx-DME) by payment categories by fiscal year.

Medical Claims Review

The Division uses the following standards to determine whether claims are sent through Medical Review:

- All hospital outlier claims
- All anesthesia claims
- All emergency department claims over \$2500

Common Billing Errors

To avoid delay or non-payment of your claim, be sure all required claim information is correct and included on the claim form. Some common billing errors can be avoided.

- Billing across months will delay payment. Split bill when services span the beginning and ending of two months.
- The member's AHCCCS ID number or provider's NPI is missing or invalid.
- The member is ineligible on the DOS.
- The member has other insurance that must be billed first (submit the EOB with the claim).
- The provider is not registered with AHCCCS, or the registration has expired. Call AHCCCS Provider Relations at (602) 417-7670, option #5. The in-state toll free number is 1-800-654-8713. The out-of-state toll free number is 1-800-523-0231.
- The provider is not registered with AHCCCS for the category of service provided.

Call AHCCCS Provider Relations at (602) 417-7670, option #5. The in-state toll free number is 1-800-794-6862. The out-of-state toll free number is 1-800-523-0231.

- The claim was filed after the filing due date.
- The diagnosis or procedure code(s) is/are invalid.
- The PA number does not belong to the service claimed or was not given by DES/DDD.
- The billing provider is not the provider that was given the PA number.
- The PA number does not belong to the member listed on the claim.
- The HCPCS code, bill type, and/or location code is/are missing or invalid.
- The claim is not legible.

Appeal Procedure

An integral part of the Division's Health Care System are the claim dispute and appeal procedures, which are used to resolve differences between members, providers and the Division.

- **Provider Claim Disputes**

All claim disputes by providers relating to an adverse decision or action by the Division shall be filed in writing with:

DES/Division of Developmental Disabilities
Office of Compliance and Review, Site Code 791A
1789 West Jefferson
Phoenix, Arizona 85007
(602) 542-6859

The Compliance and Review Unit shall review the claim dispute and provide a written decision within 30 calendar days of receipt of the claim dispute. If the provider is not satisfied with the response, a written request for a fair hearing must be filed with the Office of Compliance and Review within 30 calendar days after the mailing date of the Notice of Decision.

- **Member Appeals**

Members who have problems or grievances (complaints) regarding health care services are urged to call their DDD Support Coordinator or the Health Care Services Unit Member Services staff. DDD staff will assist the member to resolve problems or grievances.

Members may appeal any adverse decision or action by calling or writing the Office of Compliance and Review at the above address/telephone number. DES/DDD Support Coordinators may also assist the member to appeal.

All providers, including primary care physicians, specialists and ancillary service providers, upon notification of a Member Appeal, shall assist the Office of Compliance and Review or its designee in researching the appeal.

Verbal or written information to document the issue shall be supplied within the specified time frames. This may include medical records of the member. Release of this information does not require a signed release form by the member pursuant to AHCCCS Rules and Regulations (R9-22-512F.).

All medically necessary health care may continue to be provided to the member during the appeal process, if requested by the member.

Responsibilities of Members or Their Responsible Persons

Members or their responsible person(s) should, with assistance from their DES/DDD Support Coordinator when necessary:

- Maintain their ALTCS eligibility by keeping eligibility redetermination appointments.
- Select a primary care physician (PCP) within ten (10) days of notification from DES/DDD.
- Coordinate all necessary covered medical services through their PCP.
- Notify the AHCCCSA eligibility worker and the Division's Support Coordinator of changes in demographic information (i.e. address, telephone number, etc.).
- Arrive timely for scheduled appointments or notify the provider in advance and reschedule.
- Provide all available information to the PCP regarding requested medical services, and cooperate in obtaining additional information requested by the PCP.
- Show their HCS Identification Card as proof of eligibility for covered services to all health care providers (e.g. dentists, medical specialists, hospitals, and emergency rooms).
- Provide DES/DDD and all health care providers with all information, including changes in private and public insurance, third party liability, financial assistance or other benefits received by the member.
- Pursue eligibility with Children's Rehabilitative Services (CRS) when referred by DES/DDD or their PCP.
- Direct any complaints or problems to DES/DDD Health Care Services, Member Services or Office of Compliance and Review at the earliest opportunity, and
- Adult members are encouraged to complete an advance directive and file it in their PCP's medical chart.
- Participate in family-centered treatment consultations at the request of their PCP, Support Coordinator, or other district Personnel.
- Pursue eligibility with a Regional Behavioral Health Authority (RBHA) when referred by DES/DDD or their PCP.

DES/DDD Support Coordinator Roles and Responsibilities

- Intake and assessment of member needs.
- Development and implementation of an Individual Support Plan (ISP), in consultation with the PCP as needed.
- Completion of an Inventory for Client and Agency Planning (ICAP) assessment, sharing pertinent information with the PCP as appropriate.
- Coordination of services with the family and all involved persons and providers, including the PCP, to meet individual needs.
- Monitoring and periodic review of the ISP, in consultation with the PCP as needed.
- Assisting members in removing barriers to service. This may include coordination with the PCP.
- Providing closure of the ISP, and
- Assisting members and their responsible persons in meeting their responsibilities.

The PCP serves as the gatekeeper for all medical services and should facilitate the member receiving necessary services in a timely fashion. The Support Coordinator is not responsible for making medical decisions, however, can often be a valuable resource to the PCP in gathering background information about the member. It is imperative that the gatekeeper of long term care services (the Division's Support Coordinator) and the gatekeeper of medical services (the PCP) closely coordinate their efforts.

Responsibilities of the PCP

The PCP is the gatekeeper for all medical services obtained by the DD/ALTCS member. The primary purpose of this role is to assure that a single qualified professional coordinates and manages the member's medical needs. Additionally, DES/DDD expects the PCP to:

- Maintain a collegial working relationship with DES/DDD personnel in order to become familiar with the guiding values for serving persons with developmental disabilities.
- Meet all applicable Americans with Disabilities Act (ADA) requirements when providing services to members who may request special accommodations such as interpreter/translation services, assistance with physical accessibility or alternative formats.
- Deliver and/or arrange for timely, high quality, cost-effective medical and dental services consistent with accepted professional standards, understanding that it may take more time and care for the diagnosis and treatment of a person with chronic diseases and disabilities and interaction with his/her family.
- Manage the member's care to ensure continuity of care.
- Participate in the ISP process when PCP expertise is needed to ensure most appropriate placement and plan of care.
- Review the ISP submitted by the DES/DDD Support Coordinator to become familiar with the member's needs and requirements.
- Maintain the medical record for the member.
- Evaluate the member and refer to Children's Rehabilitative Services (CRS) when appropriate. Follow through on referrals made to CRS. (See Appendix F for the CRS referral form.)
- Evaluate the member and refer to a local Regional Behavioral Health Authority (RBHA) when appropriate. Follow through on referrals made to the RBHA. (See Appendix F for the RBHA referral form.)
- Discuss advance directive options with an adult member and keep on file any completed advance directive.

Prior Authorization (PA)

Examinations, routine procedures and treatments provided in a PCP's office may be performed without prior authorization. Medical laboratory tests performed in the provider's office must meet CLIA regulations. A consultation only visit conducted by a

Authorizations requested by phone that can be approved at the time of the call will be given a verbal PA number. No paper will be sent in follow up. Authorizations requested by fax or mail may be approved by phone, fax, or mail.

If an authorization is denied, the requesting provider is called and sent notice by mail with an explanation for the denial. The PCP may grieve the denial of a referral by following the steps outlined in Appeal Procedures section of this handbook. DDD does not discourage or have any policies which prevent the provider from advocating on behalf of the DD/ALTCS member.

Concurrent Review

The Health Care Services Unit (HCS) coordinates acute care concurrent review activities for DD/ALTCS members who are not enrolled in a contracted health plan or who are enrolled with Indian Health Services (IHS) and are admitted to a non-IHS facility. Concurrent review, as performed by DES/DDD, is the process of continual reassessment of the medical necessity and appropriateness of acute inpatient care during a stay in a hospital, nursing facility, other sub-acute facility in order to justify the continued inpatient stay.

Upon admission, HCS's Utilization Review Nurses either review documentation on-site or conduct a telephonic review to verify the appropriateness of continued placement and service need. For individuals who are admitted to an acute care facility for an extended period of time, HCS's Nurses perform concurrent review either on-site or telephonically for the purpose of discharge planning coordination with the appropriate inpatient facility staff.

The Division is involved in concurrent review of service need and appropriateness of placement for other than acute care. HCS coordinates the continued assessment of the need for skilled nursing services in the home and community based population. HCS, through the Ventilator Nurse and Case Management Team, also performs concurrent review for all services, including inpatient stays, for persons who are ventilator dependent. HCS, through the PASRR Coordinator, complies with federal PASRR regulations for services and placements in nursing facilities for persons with mental retardation.

As needed, District and HCS Nurses may consult with the DDD Medical Services Manager, the DES/DDD Medical Director, or the attending physician in order to develop the most appropriate plan of care for the patient.

Medical Records

The medical record is maintained by the PCP and shall include a written record of all medical services received by the member.

The medical record should include written documentation of:

- Inpatient, outpatient and emergency care
- Specialist care
- Ancillary care
- Laboratory, radiological and medical imaging tests and findings
- Prescriptions for medications and /or treatment
- Inpatient discharge summaries and histories, and
- Physicals, including a list of smoking and chemical dependencies.

Medical records are to be maintained in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective medical review and medical audit processes and which facilitates an adequate system for follow up treatment.

Medical records must be legible, signed and dated. Confidentiality of medical records must be maintained.

Written consent of the member or responsible person must be obtained before medical records may be transmitted to any other physician except other Division contractors and Division staff. DDD Support Coordinators do not require written consent of the member or responsible person in order to view or take copies of the member's medical record.

Medical records or copies of medical records written by referred physicians, practitioners, dentists or others must be forwarded to the PCP within ten (10) working days of delivery of service.

The Division's Support Coordinators are required to track and summarize the member's medical circumstances and, therefore, may at times request information from, or the opportunity to review, the medical records. Signed release from the patient is not required for Support Coordinator review of the record.

The Division performs quality management and utilization review and, as a result, reserves the right to request medical records and other information as required to perform these functions. Your office will be called in advance to arrange an appointment convenient to you to review medical records.

Appointment Procedures

AHCCCS appointment standards require that members obtain appointments the same day for emergency or urgent care and within two (2) to three (3) weeks for routine care. Referral appointments to specialists must be the same day for emergency or urgent care and within thirty (30) days for routine care. The AHCCCS office wait time standard requires that members wait no more than 45 minutes for a scheduled appointment with a primary care provider or specialist, unless the provider is unavailable due to an

emergency. Providers are expected to adhere to the AHCCCS appointment and office wait time standards. HCS may review the provider's office practices for compliance with the AHCCCS appointment and office wait time standards.

Difficult Member Arrangements

Difficult members who repeatedly violate ALTCS Rules will be accommodated. The Division does not consider an individual's abuse of emergency rooms, services or ALTCS guidelines as grounds for refusal of care. Contact Member Services at (602) 238-9028 or 1-800-624-4964 for HCS assistance with problems associated with individual members.

Emergency Care

The most cost-effective location for the delivery of most acute care services is the primary care physician's office. However, there are occasions when a member requires the services available in the urgent care unit or hospital emergency department.

The PCP must provide instructions to assigned members for accessing appropriate care, including the use of 911 and the emergency department, anytime they believe they have a life/limb threatening emergency. The provider shall not refer members to emergency rooms for non-emergent care. Remember, all providers must be AHCCCS registered and bill with an AHCCCS Provider ID number to be reimbursed by DES/DDD.

Advance Directives

An advance directive is a written (or oral) statement about a member's choices for medical treatment if s/he loses the ability to make decisions. Federal regulations require certain providers to notify adult members about their right to have an advance directive. A parent or guardian of an individual under the age of 18 years may have a written health care directive for that minor.

PCPs are encouraged to ask members to complete an advance directive and file it in the member's medical record. The member's medical record must note if s/he has an advance directive.

An advance directive may be in the form of a prehospital medical care directive (sample copy is in Appendix D); a living will; and/or a written health care power of attorney.

- A prehospital medical care directive allows an individual to direct the withholding of specific care by emergency medical and hospital personnel. Per statute, this directive is printed on an orange background and is either letter or wallet size.
- A living will is a written statement which directs and controls the health care treatment decisions that can be made on an individual's behalf. A person may use a living will without a health care power of attorney or may attach a living will to his/her health care power of attorney. If the living will is not part of a health care power of attorney, it must be witnessed and notarized.

- A health care power of attorney permits an adult to designate another adult individual(s) to make health care decisions on his/her behalf whenever the individual is unable to communicate his/her wishes. This designation must be made when the individual is of sound mind and free from duress; further, the designation must be in writing, signed, witnessed and notarized in order to be valid in Arizona. A prehospital medical care directive, a health care directive, a living will and/or a written health care power of attorney virtually replace what was generally referred to as a Do Not Resuscitate (DNR) order; however, an individual's primary care physician must also note a DNR order on the individual's medical chart.

A health care provider with moral objections to a health care directive is obliged to cooperate with the directive or promptly transfer the responsibility for the individual's care to a provider who is willing to act in accordance with the directive.

A.R.S. 36-3202, et seq., DES/DDD Policy 1504.

Fraud and Abuse

Providers are responsible to report suspected provider or member fraud and abuse. The A.R.S. and Code of Federal Regulations (CFR) provide the following definitions regarding fraud and abuse:

- Abuse (by member) means intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault (A.R.S. 46-451).
- Abuse (by provider) means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in any unnecessary cost to the Medicaid (AHCCCS) program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care (42 CFR 455.2).
- Exploitation means the illegal or improper use of an incapacitated or vulnerable person or his resources for another's profit or advantage (A.R.S. 46-451).
- Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (42 CFR 455.2).

Reporting of suspected fraud or abuse is confidential, to the degree permitted by law or allowed under AHCCCS rule. If you suspect that a provider is submitting inappropriate/inaccurate claims or rendering medical care that results in unnecessary cost to the AHCCCS/ALTCS program; or if you suspect that a member has misrepresented any facts to obtain eligibility, given his/her HCS card to another individual to obtain services, or if you have any information or for any reason suspect that a member is abusing services, you must call your Provider Relations Representative.

If a member knowingly withholds information that identifies him/her as a DD/ALTCS member, which does not allow the provider the opportunity to obtain needed prior authorization from DES/DDD, the provider may bill the member for services denied payment by DES/DDD (A.A.C. R9-22-702 C).

Cultural Competency

DES/DDD supports the philosophy that consideration of a member's needs, preferences and culture can result in increased member satisfaction and can lead to improved health outcomes. A member's culture can have a direct impact on how members access medical care and how they respond to medical treatment.

As part of DES/DDD's cultural competence program, DES/DDD provides interpreter services at no cost to fee-for-service providers (see the "Interpreter Services" section of this manual). For more detailed information on cultural competence DES/DDD encourages you to review "Culturally Competent Patient Care: A Guide for Providers and Their Staff" located in Appendix I of this manual.

Covered Services and PA Requirements

Covered Services provided to DD/ALTCS members must be medically necessary and provided by, or under the direction of a PCP, dentist, or specialist under the referral of a PCP. Nurse practitioners and physician assistants may provide covered services in appropriate affiliation with a PCP. Delegation for the provision of primary care services to a practitioner shall not diminish the responsibility of the PCP.

Subject to the limitations and exclusions in AHCCCS and ALTCS Rules, the following services will be covered at a minimum:

- Inpatient and outpatient hospital. *CALL PRIOR AUTHORIZATION.*
- Ambulatory surgery. *CALL PRIOR AUTHORIZATION.*
- Nursing Facility (NF) when placed in such facility for short-term convalescent care in lieu of hospitalization. *CALL PRIOR AUTHORIZATION.*
- Emergency room, including out-of-area emergency services.
- Physician. *CALL PRIOR AUTHORIZATION IF SERVICES RENDERED ARE OTHER THAN CPT E & M.*
- Outpatient, including those AHCCCS covered services that may be provided in a rural health clinic or Federally Qualified Health Center.
- Health Risk Assessment and Screening for members age 21 and older. This screening includes a physical exam, screening tests for cancer (mammograms, colon-rectal exams), screening for hepatitis-B every two years, and immunizations for hepatitis-B, pneumococcus, diphtheria-tetanus, influenza, rubella, and measles.
- Practitioner visits to the member's home, or natural environment, when medically necessary for the member and in agreement with the family.
- Laboratory, x-ray and medical imaging. *CALL PRIOR AUTHORIZATION IF CHARGES ARE GREATER THAN \$1,000.00.*
- DES/DDD contracts with RxAmerica for pharmacy benefit management services. Prescription drugs according to the RxAmerica formulary are covered. **The Formulary** is available at the RxAmerica website at: www.RxAmerica.com.
- Medical supplies and durable medical equipment (DME). *CALL PRIOR AUTHORIZATION IF CHARGES ARE GREATER THAN \$100.00.*
- Adaptive aids and incontinence supplies (adaptive aids list in Appendix E). *CALL PRIOR AUTHORIZATION.*
- Emergency transportation. *NOTIFY PRIOR AUTHORIZATION WITHIN 10 DAYS OF TRANSPORT.*
- Medically necessary transportation to receive covered services (i.e., to physician appointments, to laboratory sites, to pharmacies). *CALL PRIOR AUTHORIZATION.*
- Family planning including: pregnancy screening, drugs, supplies, devices and surgical procedures provided to delay or prevent pregnancy, family planning related medical and laboratory exams including ultrasound studies, treatment resulting from complications of contraceptive use including emergency

treatment, natural family planning education, screening for sexually transmitted diseases, postcoital emergency oral contraception within 72 hours of unprotected sex. Sterilizations require *PRIOR AUTHORIZATION*. Elective sterilization by hysterectomy will not be approved. Patient/guardian must comply with federal requirements to sign federal sterilization consent forms.

- Medically necessary abortions, when the pregnancy would endanger the life of the mother if the fetus were carried to term, or if the pregnancy is a result of rape. *CALL PRIOR AUTHORIZATION*.
- Rehabilitation therapies (physical, occupational, audiologic, speech) prescribed by the attending physician for an acute condition. (**See Other Programs: Therapy** in this Provider Manual.) *CALL PRIOR AUTHORIZATION*
- Respiratory therapy is covered on an inpatient or outpatient basis when prescribed by the PCP or attending physician and medically necessary to restore or improve respiratory functioning. *CALL PRIOR AUTHORIZATION*
- Audiology services to identify and evaluate hearing loss for members age 21 and older. Rehabilitation of hearing loss through other than medical or surgical means (i.e. hearing aids) for members age 21 and older is covered only when the hearing loss is due to an accident or injury-related emergent condition. *CALL PRIOR AUTHORIZATION*.
- Podiatry services to include: bunionectomies, casting for the purpose of constructing or accommodating orthotics, medically necessary orthopedic shoes that are an integral part of a brace, and medically necessary routine foot care for members with a severe systemic disease which prohibits care by a nonprofessional person. *CALL PRIOR AUTHORIZATION*.
- Orthotics and Prosthetics which are essential to the rehabilitation of the member, including scoliosis jackets. *CALL PRIOR AUTHORIZATION*.
- Early and periodic screening, diagnosis and treatment services for members under the age of 21. These services include all medically necessary Title XIX services. (**See Other Programs: EPSDT** in this Provider Manual.)
- Organ transplants deemed medically necessary are limited to the following services: kidney, cornea, heart, lung, heart/lung, liver, autologous and allogeneic bone marrow with related chemotherapy or radiotherapy. *CALL PRIOR AUTHORIZATION*.
- Dialysis, supplies, diagnostic testing and medication when provided by Medicare-certified hospitals or Medicare-certified ESRD providers. *NOTIFY PRIOR AUTHORIZATION*.
- Emergency eye care for members age 21 years and older and eyeglasses and contact lenses as the sole prosthetic device after cataract extraction. *CALL PRIOR AUTHORIZATION*. (**See Other Programs: EPSDT** of this Provider Manual for eye care services for members age birth to age 21 years.)
- Emergency dental care, extractions and medically necessary dentures for members 21 years and older. *CALL PRIOR AUTHORIZATION*. (**See Other Programs: EPSDT** of this Provider Manual for dental care services for members age birth to age 21 years.)
- Acute behavioral health services, limited to up to the first 72 hours per

episode of emergency/crisis stabilization, not to exceed 12 days per contact year for those members not enrolled in a Regional Behavioral Health Authority (RBHA). For inpatient admission, *CALL PRIOR AUTHORIZATION*. The PCP may prescribe psychiatric medication(s) to treat ADD/ADHD, mild depression or anxiety. (**See Other Programs: Behavioral Health** of this Provider Manual.)

- Nutritional assessment and nutritional supplements by any route and Total Parenteral Nutrition (TPN). (**See Other Programs: Nutrition** of this Provider Manual.) *CALL PRIOR AUTHORIZATION*
- Private duty nursing. *CALL PRIOR AUTHORIZATION*.
- Hospice for all qualified DD/ALTCS members, regardless of age. *CALL PRIOR AUTHORIZATION*.
- Home Health Nursing. *CALL PRIOR AUTHORIZATION*.
- Covered Services for Dual Eligible Qualified Medicare Beneficiaries (QMB). *CALL PRIOR AUTHORIZATION* for authorization to deliver any of the following QMB services:
 - Chiropractor services
 - Inpatient and outpatient occupational therapy
 - Inpatient psychiatric services
 - Psychological services
 - Respite services
 - Any services covered by or added to the Medicare program which are not covered by AHCCCS.

Non-Covered Services include, but are not limited to:

- Hearing aids, eye examinations for glasses, and prescription lenses for members age 21 years and older
- Physical therapy prescribed for maintenance reasons only
- Services provided in an institution for the treatment of tuberculosis or for the treatment of mental disorders
- Sex-change operations and operations to reverse voluntary sterilization
- Services or items needed only for cosmetic reasons
- Services that DES/DDD's Medical Director determines to be experimental or provided primarily for research purposes
- Personal care items, like toothbrushes and television sets in hospital rooms
- Routine podiatry (foot and ankle) services, except for members with diabetes or other chronic illnesses
- Orthognathic (jaw) surgery for members age 21 years and older

(Non-Covered Services-Continued)

- Abortions (unless the mother is pregnant through rape or incest or an abortion is needed to save the life of the mother)
- Abortion counseling
- Medical services provided to a person who is an inmate of a public institution or who is in the custody of a state mental health facility.
- Infertility treatment
- Hysterectomies
- Hysteroscopic tubal sterilization (such as Essure Micro-Insert)

Other Programs

Children's Rehabilitative Services (CRS)

CRS, part of the Arizona Department of Health Services (ADHS), provides health care services to individuals with special health care needs. CRS is a statewide, State and Federally funded program which serves individuals under 21 years of age, residing in Arizona at the time of service, who meet the medical and financial criteria established by ADHS. Generally, all DD/ALTCS members meet CRS financial requirements.

CRS accepts for treatment those individuals who have handicapping or potentially handicapping conditions that are likely to improve through medical, surgical, or therapy modalities. The following three criteria must be present:

1. Specialized treatment is necessary;
2. Significant, functional improvement is realistically achievable; and
3. Long-term follow-up may be required for maximum achievable results.

Members under the age of twenty-one (21) who may have a CRS eligible condition must be referred to CRS by completing a CRS application (copy of the application form is in Appendix F) to the appropriate CRS regional office, unless the member chooses to use private insurance. CRS regional offices are located at:

1215 N. Beaver, Flagstaff, AZ 86001	520/773-2053 or 800/232-1018
124 W. Thomas Rd. Phoenix, AZ 85013	602/650-6400 or 800/392-2222
2600 N. Wyatt Drive, Tucson, AZ 85712	520/324-5437 or 800/231-8261
2400 Avenue A, Yuma, AZ 85364	520/344-7095 or call collect

FFS providers are responsible for initiating an application to CRS for members potentially eligible under the CRS program. Referrals for service from CRS should be tracked and monitored by the FFS provider, with follow-up documented in the medical record. Any coordination of care difficulties should be reported to the HCS Prior Authorization Unit.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Federally mandated, EPSDT services provide comprehensive health care, as defined in A.A.C. R9-22-213, through primary prevention, early intervention, diagnosis and medically necessary treatment of physical and behavioral health problems for eligible members under 21 years of age. EPSDT also provides for all medically necessary services to treat or ameliorate physical and behavioral health disorders, a defect, or a condition identified in an EPSDT screening, regardless of whether the treatment or services is covered for other Medicaid eligible members 21 years of age and older. Limitations and exclusions, other than the requirement for medical necessity, do not apply to EPSDT services.

FFS providers must (AHCCCS Medical Policy Manual 430 EPSDT):

1. Provide EPSDT services in accordance with A.A.C. R9-22-213 and 42 CFR 441, Subpart B, and Section 1905 (R) of the Social Security Act.
2. Provide and document EPSDT screening services in accordance with the AHCCCS Periodicity Schedule. (See Appendix G.)
3. Refer members for follow up, diagnosis and treatment, ensuring that treatment is initiated within 60 days of screening services.
4. If appropriate, document in the medical record, the member decision not to participate in the EPSDT Program.
5. Document a health database assessment on each EPSDT participant. The database shall be interpreted by a physician or licensed health professional who is under the supervision of a physician.
6. Provide health counseling/education at initial and follow up visits.
7. Coordinate care with AzeIP and Children's Rehabilitative Services (CRS).

Screening Requirements:

1. EPSDT screenings must include:
 - A comprehensive health and developmental history (including physical, nutritional and behavioral health assessments)
 - a. Developmental Screening** – For children from birth through age 5, a developmental history of the infant or child must be obtained and augmented at each well-child scheduled visit and documented in the child's medical record. A child between the ages of 3 through 5 years may be eligible for further assessment if he/she experiences difficulties that interfere with normal development in these areas:
 - i. Fine and gross motor skills
 - ii. Behavioral/social skills
 - iii. Self-help skills
 - iv. Speech/language
 - v. Problem-solving skills, and
 - vi. Cognition/readiness skills

After the age of 5 years, developmental screening should continue to include information related to cognitive, language, and psychosocial development. The following tests are strongly recommended for children up to 3 years of age and may be used up to the age of 5 years:

- i. Denver Developmental Screening Test (DDST II)
- ii. Revised Developmental Screening Inventory
- iii. Gesell Developmental Examination

For children 3 through 5 years of age, the Early Screening Inventory (Meisels) is available. This instrument is also available in Spanish.

Particular care should be taken to note “red flags” signaling behavioral health problems at each visit. To obtain more information on developmental screening instruments, see Bright Futures Web site: www.brightfutures.org

If there is a suspicious outcome on prescreening or screening, and there is no established condition, or the FFS provider does not feel knowledgeable about the assessment instrument/interpretation, then a referral for a developmental evaluation by the Arizona Early Intervention Program providers (AzEIP) is appropriate. Contact the DES/DDD Birth to Five Coordinator, 1789 W. Jefferson, Phoenix, AZ 85006, 480/231-0960, for more information (See **Contacting Us** in the front of this Manual.)

2. A comprehensive unclothed physical examination
3. Appropriate immunizations according to age and health history
4. Laboratory tests (including blood lead screening assessment appropriate to age and risk, anemia testing and diagnostic testing for sickle cell trait if a child has not been previously tested with sickle cell preparation or a hemoglobin solubility test)
5. Health Education
6. Appropriate oral health screening, intended to identify gross tooth decay or oral lesions, conducted by a physician, physician’s assistant or nurse practitioner
7. Appropriate vision, hearing, and speech testing and diagnosis, as well as treatments for defects in vision and hearing, including provision of eyeglasses and hearing aids. Appropriate therapies, including speech therapy, are also covered under EPSDT, and
8. Tuberculin skin testing as appropriate to age and risk. Children at increased risk of tuberculosis (TB) include those who have contact with persons:
 - a. Confirmed or suspected as having TB
 - b. In jail or prison during the last five years
 - c. Living in a household with an HIV-infected person or the child is infected with HIV, and
 - d. Traveling/immigrating from, or having significant contact with person indigenous to, endemic countries.

EPSDT Standards

1. Immunizations – EPSDT covers all child and adolescent immunizations as specified in the AHCCCS EPSDT Periodicity Schedule. All appropriate immunizations must be provided to bring, and maintain, each EPSDT member’s immunization status up-to-date.

Providers must coordinate with the Arizona Department of Health Services Vaccines for Children program in the delivery of immunization services. Immunizations must be provided according to the Advisory Committee on Immunization Practices Recommended Schedule.

2. Eye Examinations and Prescriptive Lenses – EPSDT covers eye examinations as appropriate to age according to the AHCCCS EPSDT Periodicity Schedule and as medically necessary. Prescriptive lenses are provided to correct or ameliorate defects, physical illness and conditions discovered by EPSDT screenings, subject to medical necessity.

3. Blood Lead Screening – EPSDT covers blood lead screening. All children are considered at risk and must be screened for lead poisoning. All children must receive a screening blood lead test at 12 months and 24 months of age. Children between the ages of 36 months and 72 months of age must receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test result of equal to or greater than 10ug/dl obtained by capillary specimen or fingerstick must be confirmed using a venous blood sample. A verbal risk assessment must be completed at each EPSDT visit for children ages 6 months through 72 months (6 years) to assist in determining risk. Appropriate follow-up must be provided.

4. Organ and tissue transplantation services – EPSDT covers medically necessary nonexperimental/noninvestigational organ and tissue transplants approved for reimbursement in accordance with respective transplant policies, as noted in Chapter 300 and Appendix C of the AHCCCS Medical Policy Manual. See Chapter 300 and Appendix C of the AHCCCS Medical Policy Manual for discussion of AHCCCS covered transplantations.

5. Nutritional Assessment and Nutritional Therapy –
Nutritional Assessments: Nutritional assessments are conducted to assist EPSDT members whose health status may improve with nutrition intervention. DES/DDD covers the assessment of nutritional status provided by the member’s primary care provider (PCP) as a part of the EPSDT screenings specified in the AHCCCS EPSDT Periodicity Schedule, and on an inter-periodic basis as determined necessary by the member’s PCP.

Nutritional Therapy: DES/DDD covers nutritional therapy for EPSDT eligible members on an enteral, parental or oral basis when determined to be medically necessary to provide either complete daily dietary requirements, or to supplement a member’s daily nutritional and caloric intake.

- a. Enteral nutritional therapy: Provides liquid nourishment directly to the digestive tract of a member who cannot ingest an appropriate amount of calories to maintain an acceptable nutritional status. Enteral nutrition is commonly provided by jejunostomy tube (J-tube), gastrostomy tube (G-tube) or nasogastric (N/G) tube. Prior authorization is required for parenteral nutritional feedings.
- b. Parenteral nutritional therapy: Provides nourishment through the venous system to members with severe pathology of the alimentary tract, which does not allow absorption of sufficient nutrients to maintain weight and strength. Prior authorization is required for parenteral nutritional feedings.
- c. Commercial Oral Supplemental Nutritional Feedings: Provides nourishment and increases caloric intake as a supplement to the member's intake of other age appropriate foods, or as the sole source of nutrition for the member. Nourishment is taken orally and is generally provided through commercial nutritional supplements available without a prescription.

Prior authorization is required for commercial oral nutrition supplements unless the member is also currently receiving nutrition through enteral or parenteral feedings. Prior authorization is not required for the first 30 days if the member requires commercial oral nutritional supplements on a temporary basis due to an emergent condition.

Medical necessity for commercial oral nutritional supplements must be determined on an individual basis by the member's PCP or attending physician, using at least the criteria stated in the Chapter 400 of the AHCCCS Medical Policy Manual. The PCP or attending physician must use the "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements" form, which can be found on the AHCCCS website at: http://www.ahcccs.state.az.us/Regulations/OSPPolicy/chap400/CP_Policy430.pdf

The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must document that the PCP or attending physician has provided nutritional counseling as part of the EPSDT services provided to the member. The documentation must specify alternatives that were tried in an effort to boost caloric intake and/or change food consistencies before considering commercially available nutritional supplements for oral feedings, or to supplement feedings.

- d. Criteria for Medical Review and Prior Authorization for Supplemental Nutritional Feedings: The Primary Care Provider (PCP) or physician specialist must make the request. A Physician has requested nutritional feeding by a physician assistant or nurse practitioner. In order to make this request, the physician assistant or nurse practitioner must be under the medical management of the PCP. A request made by a physician specialist must be routed through the PCP for continuity of care. Requests shall be routed through appropriate channels of the Prior Authorization Nurse in Health Care Services for fee-for-service members. Items

to be submitted for medical review include:

1. All current diagnoses.
 2. Current or recent (within 6 months) laboratory data such as chemistry panel, iron binding studies, etc.
 3. Growth chart with current height and weight history. A family history of unusual growth patterns, i.e., emaciated, short stature, etc. should be included, as appropriate.
 4. The history of ambulation or physical activities.
 5. The history of gastrointestinal health.
 6. A current nutritional assessment and a summary of client/caregiver education done by a registered dietitian.
 7. A three (3), five (5) or seven (7) day diary of dietary intake, as appropriate.
 8. The speech or occupational therapy evaluation related to any oral-motor, dentition, chewing or swallowing problems, as applicable.
 9. Current medications including an analysis of possible medication/nutrient interaction affecting absorption.
 10. All alternative approaches to the use of oral-enteral formulas attempted and the outcomes.
 11. The specific goals of oral-enteral formulas with a follow-up and weaning plan over a specific time frame.
- e. Monitoring of the consumer's progress on the oral-enteral formula is the responsibility of the Primary Care Provider (PCP) or designee and shall include:
1. Nutritional assessment follow-up at the following intervals:
 - a. Consumers on oral-enteral formulas less than five (5) years
Shall receive an assessment every three (3) months.
 - b. Consumers on oral-enteral formulas five (5) to fourteen (14) years shall receive an assessment every six (6) months.
 - c. Consumers on oral-enteral formulas over fourteen (14) years shall receive an assessment annually.
 2. Alternative to commercially prepared formulas should be considered whenever possible including blenderized foods for individuals beyond the normal formula age (3 years) if possible.
 3. Consumers should be evaluated by WIC to determine if they meet the AHCCCS EPSDT policy requirements to determine medical necessity.
 - a. If medical necessity is met, WIC staff will refer the consumer back to their primary care doctor to process the request through the Prior Authorization Nurse in Health Care Services.

- b. If the AHCCCS EPSDT Policy requirements are not met, then WIC will assess and provide formula if applicable.
- 4. The Certificate of Medical Necessity for Commercial oral Nutrition Supplements must document that the PCP or attending physician has provided nutritional counseling as part of the EPSDT service
- g. Consumer Management for Supplemental Nutritional Feeding
 - 1. Consumers should be followed by:
 - a. The health plan.
 - b. The agency providing the formula.
 - c. The Division's Health Care Services for fee-for-service.
- h. Authorization Process for Supplemental Nutritional Feeding
 - a. Definitions
 - 1. Enteral – within or by way of the intestine: For the purposes of this policy, enteral will mean the delivery of nutritional feedings to the intestinal tract by way of a feeding tube such as naso-gastric, oral-gastric, gastrostomy, jejunostomy or a gastrostomy button.
 - 2. Oral-any nutritional formula or food that is ingested by mouth.
 - b. Authorization guidelines
 - 1. The certificate of Medical Necessity for commercial Oral Nutritional supplements must indicate which criteria were met when assessing the medical necessity of providing commercial oral nutritional supplements. The health plan Medical Director or the Division Medical Director must also deem oral-enteral formula or supplemental providing feedings as medically necessary for Fee-for-Service. At least two of the following criteria must be met.
 - a. The consumer is at or below the 10th percentile on the appropriate growth chart for their age, gender or disability, e.g., Down syndrome, for greater than three (3) months.
 - b. The consumer has reached a plateau in growth and/or nutritional status for greater than six (6) months pre-pubescent).
 - c. The consumer has demonstrated a decline in growth status within the last three (3) months.

- d. The consumer is able to obtain/eat no more than 25% of his/her nutritional requirement from normal food sources.
 - e. Absorption problems as evidenced by emesis, diarrhea, dehydration, weight loss and intolerance to milk or formula products have been ruled out.
 - f. Unsuccessful trials of alternatives such as blenderized foods have been documented over a reasonable period of time with the involvement of a nutritionist.
 - g. The member requires nutritional supplements on a temporary basis due to an emergent condition; i.e. post hospitalization.
 - h. The member is at high risk for regression due to a chronic disease or condition and there are no alternatives for adequate nutrition.
2. The Prior Authorization Nurse will submit all documentation for evaluation by the Division’s Medical Director regarding fee-for-service members.
 3. Re-authorization for supplemental nutritional feeding formula will be determined by the age of the consumer (based on the nutritional evaluation for age set forth in Section 604.19.1.b).

As part of the physical examination, the physician, physician’s assistant or nurse practitioner should perform an oral health screening. A screening is intended to identify gross dental or oral lesions, but is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan. Depending on the results of the oral health screening, referral to a dentist should be made according to the following timeframes:

Category	Recommendation for Next Dental Visit
Emergent	Within 24 hours of request
Urgent	Within 3 days of request
Routine	within 45 days of request

An oral health screening should be part of an EPSDT screening conducted by the PCP, however it does not substitute for examination through direct referral to a dentist. PCPs are expected to refer EPSDT member for appropriate services based on needs identified through the screening process and for routine dental care based on the AHCCCS EPSDT Periodicity Schedule. Evidence of this referral should be documented on the EPSDT form. In addition to PCP referrals, EPSDT members are allowed self-referral to a dentist who is an AHCCCS registered provider.

Note: Although the AHCCCS EPSDT Periodicity Schedule identifies when routine referrals begin, PCPs may refer EPSDT members for a dental assessment at an earlier age if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/or treatment by a dental professional.

EPSDT covers the following dental services:

- a. Emergency dental services including:
 - Treatment for pain, infection, swelling and/or injury
 - Extraction of symptomatic, infected and non-restorable primary and permanent teeth, as well as retained primary teeth, and
 - General anesthesia or conscious sedation when local anesthesia is contraindicated or when management of the patient requires it.
- b. Preventative dental services provided as specified in the AHCCCS EPSDT Periodicity Schedule, including:
 - Complete intraoral examinations
 - Radiology procedures which are screening in nature for diagnosis of dental abnormalities, including panography or full-mouth x-rays, supplemental bitewing x-rays, and occlusal or periapical films as needed
 - Oral prophylaxis performed by a dentist or dental hygienist which includes instruction in self-care oral hygiene procedures
 - Application of topical fluorides. (Use of prophylaxis paste containing fluoride and fluoride mouth rinses are not considered separate fluoride treatments), and
 - Dental sealants on all non-carious permanent first and second molars and second primary molars.
- c. All therapeutic dental services will be covered when they are considered medically necessary but may be subject to prior authorization. These services include but are not limited to:
 - Periodontal procedures, scaling/root planning, curettage, gingivectomy, osseous surgery
 - Space maintainer when posterior primary teeth are lost permanently
 - Crowns
 - Stainless steel crowns may be used for both primary and

permanent posterior teeth; composite, plastic or acrylic crowns must be used for anterior primary teeth, or

Cast non-precious or semi-precious crowns for members 18 through 20 years of age on all functional permanent endodontically treated teeth, except third molars

Pulp therapy for permanent and primary teeth, except third molars unless it is functioning in place of a missing molar

Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations unless the member is 18 through 20 years of age and has had endodontic treatment, and

Dentures, orthodontics and orthognathic surgery when medically necessary and determined to be the primary treatment of choice or an essential part of an overall treatment plan designed by the PCP in consultation with the dentist.

7. Cochlear Implantation – Cochlear implantation provides an awareness and identification of sounds and facilitates communication for persons who have profound, sensorineural hearing loss (nerve deafness). DES/DDD covers medically necessary services for cochlear implantation, as described in Chapter 300, Policy 310 of the AHCCCS Medical Policy Manual, for EPSDT members eighteen months of age or older who meet the following criteria:

Have a diagnosis of bilateral profound sensorineural deafness, with little or no benefit from a hearing (or vibrotactile) aid, as established by audiologic and medical evaluation

Deafness may be prelingual/perilingual or postlingual

Have an accessible cochlear lumen structurally suited to implantation, with no lesions in the auditory nerve and acoustic areas of the central nervous system, as demonstrated by CT scan or other appropriate radiologic evaluation

Demonstrate no contraindications to surgery, and

Demonstrate age appropriate cognitive ability to use auditory clues.

Cochlear implantation requires prior authorization.

8. Conscious sedation – DES/DDD covers conscious sedation for members receiving EPSDT services. Conscious sedation provides a state of consciousness that allows the member to tolerate an unpleasant procedure while remaining able to continuously maintain adequate cardiovascular and respiratory function as well as the ability to respond purposely to verbal command and/or tactile stimulation.

Coverage is limited to the following procedures:

- a. Bone marrow biopsy with needle or trocar
- b. Bone marrow aspiration
- c. Intravenous chemotherapy administration, push technique
- d. Chemotherapy administration into central nervous system by spinal puncture
- e. Diagnostic lumbar spinal puncture, and
- f. Therapeutic spinal puncture for drainage of cerebrospinal fluid.

Additional applications of conscious sedation for members receiving EPSDT services will be considered on a case by case basis and require medical review and prior authorization by the DES/DDD Medical Director.

9. Behavioral health services as described in Chapter 300, Policy 310 of the AHCCCS Medical Policy Manual

10. Religious Non-Medical Health Care Institution Services as described in Chapter 300, Policy 310 of the AHCCCS Medical Policy Manual

11. Case Management Services

12. Chiropractic Services, and

13. Personal Care Services

EPSDT Periodicity Schedule

AHCCCS has established an EPSDT Periodicity Schedule which describes at what age children should be seen for preventive care and which services are required at each age. A copy of the Periodicity Schedule is in Appendix G. The FFS Provider is required to adhere to the Periodicity Schedule and to document screening and treatment results on the EPSDT Tracking Forms. The tracking Forms may be found on the AHCCCS website at <http://www.azahcccs.gov>

As examples, EPSDT visits should be coded as follows on the CMS 1500:

<u>Patient Status</u>	<u>ICD-9 Diagnosis Code</u>	<u>CPT-4 Procedure Code</u>
New Patient EPSDT	V20.2	99381
Established Pt. with Immunization	V20.2	99392
	V20.2	90707

Follow-up visits for an acute condition (i.e., otitis) can also be occasions for an EPSDT screen. Code the CMS 1500 with the appropriate ICD-9 diagnosis codes (i.e., 382.9 for otitis and V20.2 for EPSDT visit) and indicate the appropriate procedure code(s) applicable to each diagnosis (i.e., 99392 for diagnoses 1 and 2).

Incontinence Supplies

DDD provides incontinence briefs, including pull-ups for children age 3 years through age (20) twenty who are eligible for the DD/ALTCS program to prevent skin breakdown and to enable participation in social, community, therapeutic and education activities. The member must be incontinent due to a documented disability that caused incontinence of bowel and/or bladder. The benefit is limited to 240 briefs per month, unless the prescribing Physician presents evidence of medical necessity for more than 240 briefs per month for a member diagnosed with chronic diarrhea or spastic bladder. Prior authorization is required.

Vaccines for Children (VFC) Program

FFS Providers who treat DD/ALTCS members under age 18 years must participate in the VFC Program. This program is coordinated through the Arizona Department of Health Services (ADHS). To participate, providers must complete a Provider Enrollment form and a Provider Profile. These documents may be obtained from ADHS by calling the ADHS VFC representative at 602/364-3642. Providers receive information on ordering vaccines from ADHS after the enrollment process is completed. Vaccines for VFC eligible children may be ordered once every two months. Questions regarding VFC provider enrollment and vaccine ordering should be directed to the ADHS VFC program at (602) 364-3642.

Therapy

If therapy is post surgery or acute condition, i.e. fracture, the therapy must be designed to restore a similar level of functions to what was present prior to surgery/acute condition, unless the intervention was designed to increase function, as with release of contractures. In this case, post intervention therapy is covered as rehabilitative.

DES/DDD has adopted a teaching model for the delivery of therapies (physical, speech, occupational). The FFS Provider is encouraged and requested to adhere to this model which includes education of and participation from the member and caregiver(s). DES/DDD believes that therapy services are an essential component of programs for adults and children who need to maintain or improve their functional capabilities and physical well-being. The direction and oversight of a therapist is a valuable resource which must be effectively utilized to achieve maximum benefit and cost-effectiveness. Ideally there is a shared effort between the therapist and the family, caregivers, service providers and teachers. Activities recommended by a therapist should be integrated into the member's daily routine and, in most cases, be performed frequently and routinely by the member and/or caregiver(s).

In the teaching model, the primary role of the therapist is:

- to evaluate the member,
- to recommend and design sound activities and methodologies,
- to teach and assist caregivers to incorporate these into the member's daily routine,
- to provide direct therapy when necessary and appropriate, and
- to evaluate and monitor implementation and progress.

Behavioral Health

Emergency/crisis behavioral health services are covered for DD/ALTCS members. For those members not enrolled in a RBHA (Regional Behavioral Health Authority) at the time of the emergency, up to 72 hours of emergency psychiatric hospitalization may be authorized by HCS's Prior Authorization Unit. This service is limited to 12 days per contract year for those members not enrolled in a RBHA.

Each Regional Behavioral Health Authority (RBHA) is required to provide a full array of medically necessary behavioral health services. Members may also receive behavioral health services from their PCP, depending on the PCP's level of comfort, when presenting with certain mental health disorders (ADD/ADHD, mild depression or anxiety). The PCP may consult with a RBHA psychiatrist about diagnostic and treatment questions or may arrange for a DD/ALTCS member to have a one time face-to-face consultation with a RBHA psychiatrist when clinically indicated. The PCP may also elect to refer the member to a RBHA as soon as a behavioral health need is identified. There are multiple points of entry into the RBHA behavioral health system. The member may apply, the DDD Support Coordinator, PCP, guardian, parent, or anyone familiar with the person may assist with a referral to the local RBHA. (See Appendix H for a map and names/addresses of the Arizona RBHAs. Also included is a RBHA referral form, which should be used for referrals and consultations.)

FFS providers are responsible for initiating an application to the RBHA for members potentially eligible under the RBHA system, when the behavioral health need is identified by the FFS provider. Referrals for service from the RBHA should be tracked and monitored by the FFS provider, with follow-up documented in the medical record. Any coordination of care difficulties should be reported to the HCS Administrator.

Nutrition

Enteral nutrition by any route (i.e., mouth, tube), is covered for any age member, based on medical necessity. Enteral nutrition includes nutritional products which serve as either the primary source of nutrition and/or supplemental nutrition. Supplies to administer the feeding are also covered. The FFS Provider is also expected to assist in the development and implementation of protocols and procedures to encourage weaning from enteral nutrition and to assist the caregiver in the weaning process.

TPN is covered for any age member, based on medical necessity. Supplies and administration of parenteral nutrition are covered. If TPN is required for more than six (6) months, continued need beyond the initial six months requires PA, with annual review thereafter for continued authorization.

Women, Infants and Children (WIC)

DES/DDD recognizes the value of the Women, Infants & Children (WIC) program in providing nutritional guidance as well as beneficial food commodities. All ALTCS members are eligible for services typically provided by WIC through the DD/ALTCS program and its FFS providers. Members cannot be denied by first requiring members to utilize WIC. ALTCS members should be evaluated by WIC to determine if they meet the AHCCCS EPSDT policy requirements to determine if medically necessary. If medical necessity is met, WIC will refer member back to PCP to process request to Fee-For-Service. If the AHCCCS EPSDT policy requirement is not met, then WIC will assess and provide formula if applicable. Members cannot be denied by first requiring member to utilize WIC.

Dental Services

Children are eligible under EPSDT for a wide range of dental services. Prophylaxis and fluoride treatment is covered once every 6 months. Sealants are covered for non-carious permanent first molars. Children may receive dental treatment for traumatic injuries, caries, developmental abnormalities, evidence of infection, bleeding, or inflammation of gums, and/or decay of erupting teeth.

Dental implants are not covered. Dental emergencies must meet the AHCCCS definition of an emergency medical condition [R9-22-101(44)]. Medically necessary dentures are partial or full dentures determined to be the best treatment to alleviate a medical condition. Call Prior Authorization.

Home Modifications

DES/DDD covers the cost of home modifications or items which will allow members to function as independently as possible. Typical modifications are widening of doorways for better access, replacing bathroom tubs with roll-in-showers for wheelchair accessibility and building ramps to better negotiate entrance doorways.

This service must be determined medically necessary and prescribed by the primary care provider. Please refer members requesting this service to their DDD Support Coordinator to initiate the referral process.

Augmentative Communication

DES/DDD covers augmentative/alternative communication devices for members who have a functional gap between receptive and expressive language skills. Based on individual need, devices may range from simple picture books to hi-tech electronic communication aids.

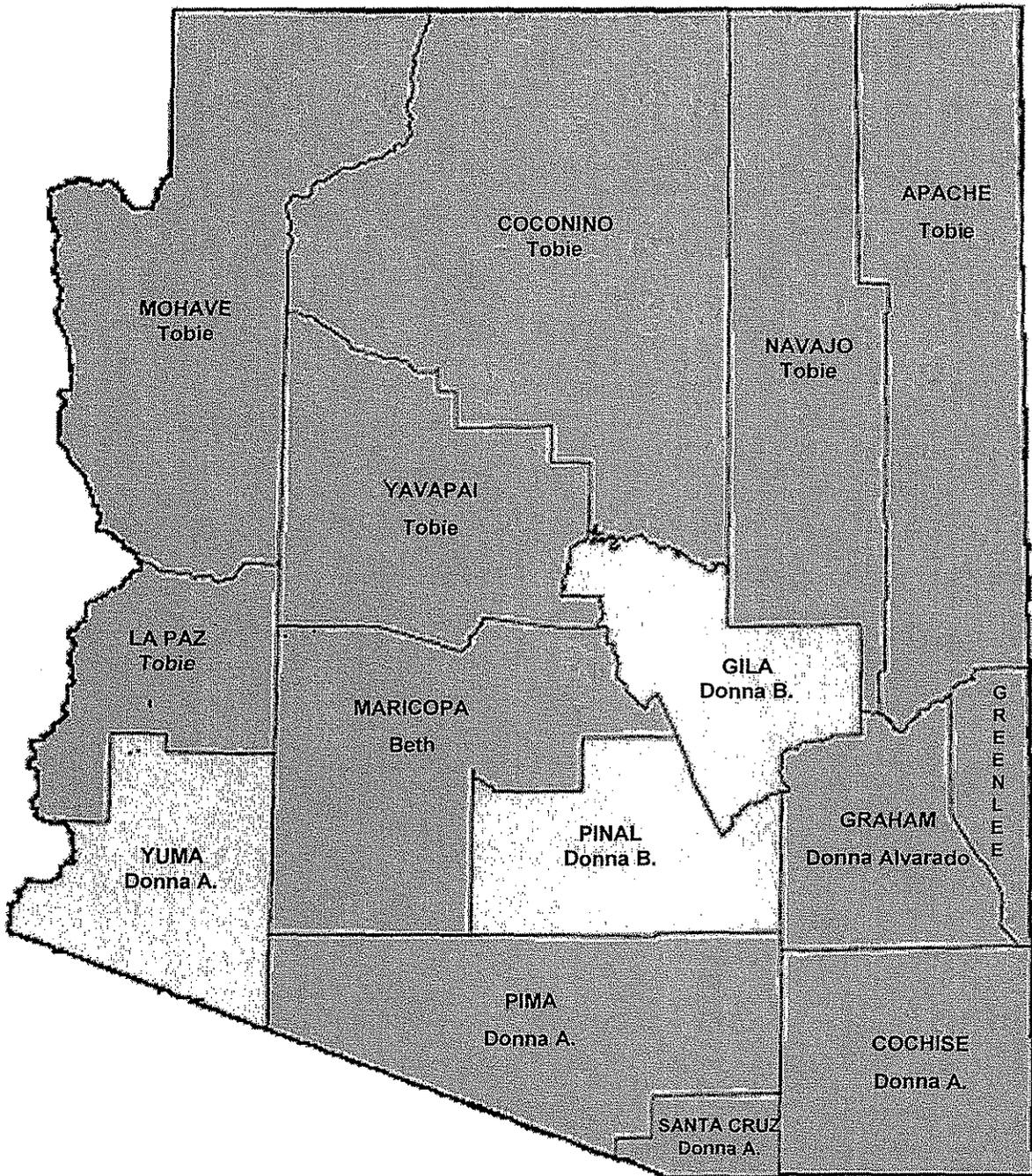
This service must be determined medically necessary and prescribed by the primary care provider. Please refer members requesting this service to their DDD Support Coordinator to initiate the referral process.

Transition and Coordination of Care

In the event that the agreement between the Division and a fee-for-service provider is terminated, with or without cause, or the Division contracts with a health plan in the FFS Provider's area, the provider shall assist the Division in the transition of members to other health care providers. In addition, the provider shall assist with the coordination of care for members entering or leaving DD/ALTCS services. Such assistance and coordination shall include, but is not limited to, the forwarding of medical and other records, the facilitating and scheduling of record transmittal and medically necessary appointments. The cost of reproducing and forwarding medical charts and other materials shall be borne by the provider.

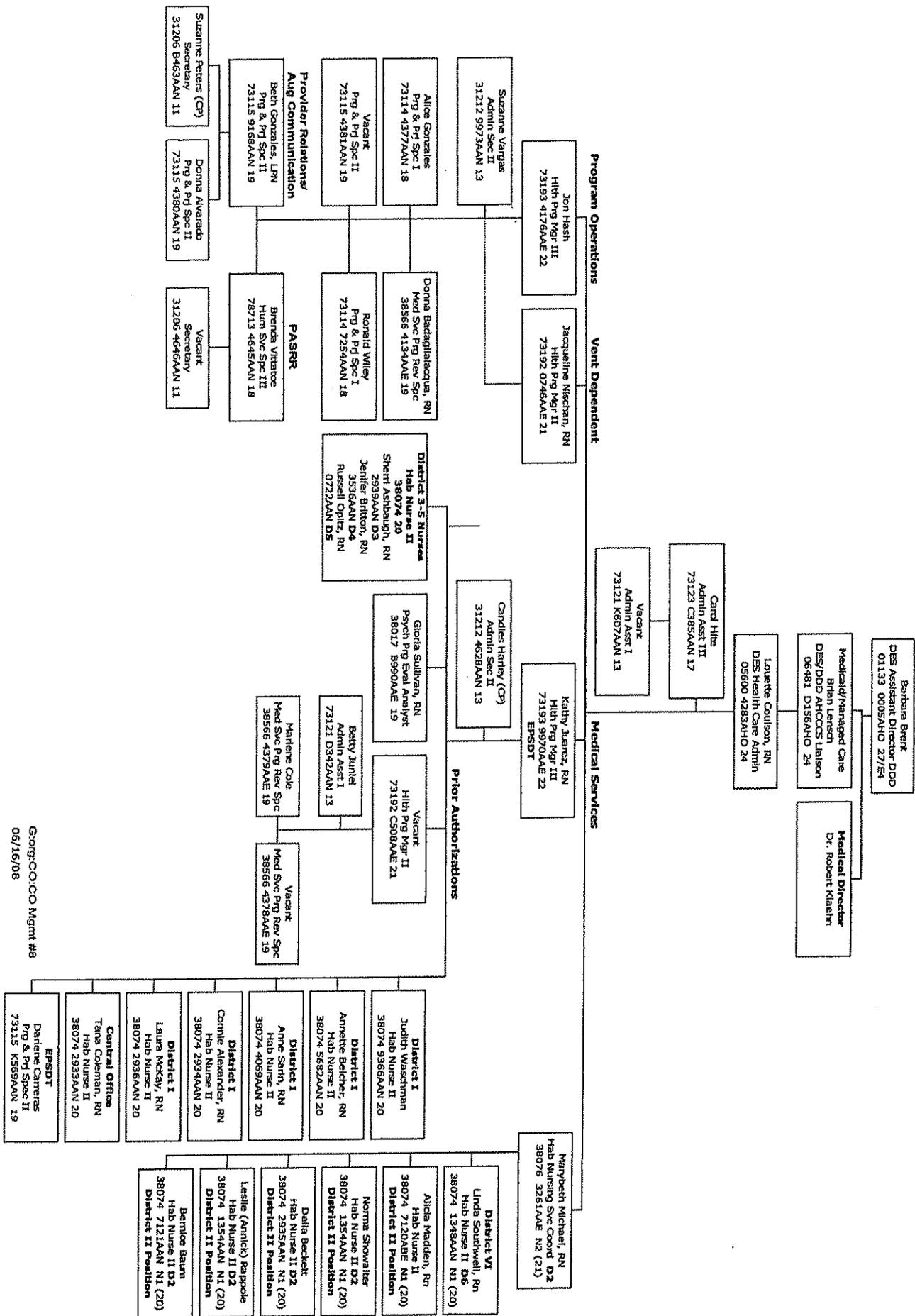
APPENDIX A:
HCS TABLE OF ORGANIZATION
AND
PROVIDER RELATIONS GEOGRAPHIC ASSIGNMENT MAP

Division of Developmental Disabilities
Health Care Services
Arizona Provider Relations



Tobie Trejo	928-526-0334	(DDD Office fax) 928-773-8495
Donna Badagialacqua	602-238-9028 ext. 6026	602-238-9294
Donna Alvarado	520-519-1719	520-747-3469
Beth Gonzales	602-238-9028 ext. 6010	602-238-9294

DIVISION OF DEVELOPMENTAL DISABILITIES
Central Office - Health Care Services



George/CO/CO Mgmt #8
06/16/08

APPENDIX B:
DISTRICT NURSE CONTACTS

DDD NURSES LIST

NAME	ADDRESS	SITE CODE	PHONE AND VOICE MAIL	PAGER
ALICIA MADDEN AMadden@azdes.gov	BOX 13178 TUCSON, AZ 85711	275-F	520-519-1734 Ext. 1088	NONE
ANN LYNCH ALynch@azdes.gov	BOX 13178 TUCSON, AZ 85711	275-F	520-519-1736 Ext. 1090	NONE
ANNETTE LAMMON-BELCHER ABelcher@azdes.gov	2200 N CENTRAL, SUITE 207 PHOENIX, AZ 85004	795-M	602-238-9028 Ext. 6022	NONE
ANNICK RAPPOLE ARappole@azdes.gov	BOX 13178 TUCSON, AZ 85711	275-F	520-519-1733 Ext. 1087	NONE
BERNICE BAUM BerniceBaum@azdes.gov	ATPT BOX 13178 TUCSON, AZ 85732	275-F	520-519-1726 Ext. 1086	NONE
CANDY LIVINGSTON CLivingston@azdes.gov	2200 N CENTRAL, SUITE 207 PHOENIX, AZ 85004	795-M	602-817-6716	NONE
CHERYL MENDOZA Cmendoza@azdes.gov	910 N BROAD STREET GLOBE, AZ 85501	510-F	VM 602-817-6713	NONE
CONNIE ALEXANDER ConstanceAlexander@azdes.gov	2200 N CENTRAL, SUITE 207 PHOENIX, AZ 85004	795-M	602-817-6725	NONE
CONNIE THOMPSON Cthompson@azdes.gov	4000 N CENTRAL PHOENIX, AZ 85012	868F-2	602-264-0546	NONE
CYNTHIA GUZMAN CynthiaGuzman@azdes.gov	2200 N CENTRAL, SUITE 207 PHOENIX, AZ 85004	795-M	602-238-9028 Ext. 6015	NONE
DARLENE INMAN Dinman@azdes.gov	1220 S 4TH AVENUE YUMA, AZ 85364	433-F	928-782-7523 VM 602-817-6714	NONE
DAWN STODDARD Dstoddard@azdes.gov	2200 N CENTRAL, SUITE 207 PHOENIX, AZ 85004	795-M	602-238-9028 Ext. 6014	NONE
DEE BECKETT Dbeckett@azdes.gov	ATPT BOX 13178 TUCSON, AZ 85732	275-F	520-745-5588	NONE
DONNA POOL Dpool@azdes.gov	519 E BEALE STREET, SUITE 155 KINGMAN, AZ 86401	402-F	928-753-4868 VM 800-624-4964	Cell 928-716-0571 VM 602-817-6717
GLORIA SULLIVAN Gsullivan@azdes.gov	2200 N CENTRAL, SUITE 506 PHOENIX, AZ 85004	795-M	602-238-9028 Ext. 6033	NONE
JACKIE NISCHAN Jnischan@azdes.gov	2200 N CENTRAL, SUITE 207 PHOENIX, AZ 85004	795-M	602-238-9028 Ext. 6016	NONE
		795-M	602-238-9028 Ext. 6034	NONE
JENIFER BRITTON Jbritton@azdes.gov	232 LONDON BRIDGE ROAD LAKE HAVASU CITY, AZ 86403	421-F	VM 602-817-6720 VM 800-624-4964	NONE
JUDY WACHSMAN JWachsman@azdes.gov	2200 N CENTRAL, SUITE 207 PHOENIX, AZ 85004	795-M	602-238-9028 Ext. 6021	NONE
KATHY JUAREZ Kjuarez@azdes.gov	2200 N CENTRAL, SUITE 506 PHOENIX, AZ 85004	795-M	602-238-9028 Ext. 6035	NONE
LAURA MCKAY LMckay@azdes.gov	2200 N CENTRAL, SUITE 207 PHOENIX, AZ 85004	795-M	602-817-6724	NONE
LINDA SOUTHWELL Lsouthwell@azdes.gov	1938 THATCHER BOULEVARD SAFFORD, AZ 85546	631-F	928-428-0474 Ext.1140	NONE
LORI WHETTEN Lwhetten@azdes.gov	2500 E. COOLEY #410 SHOW LOW, AZ 85901	336-F	VM 602-817-6721	NONE
LOUETTE COULSON Lcoulson@azdes.gov	2200 N CENTRAL, SUITE 207 PHOENIX, AZ 85004	795-M	602-238-9028 Ext. 6012	NONE
MARLENE COLE Mcole@azdes.gov	2200 N CENTRAL, SUITE 506 PHOENIX, AZ 85004	795-M	602-238-9028 Ext. 6038	NONE
MARYBETH MICHAEL Mmichael@azdes.gov	4710 E 29TH STREET TUCSON, AZ 85711	275-F	520-519-1731 Ext. 1085	NONE
NORMA SHOWALTER Nshowalter@azdes.gov	BOX 13178 TUCSON, AZ 85711	275-F	520-519-1726 Ext. 1084	NONE
RUSSELL OPITZ Ropitz@azdes.gov	ATPC BOX 1467 COOLIDGE, AZ 85258	575-F	520-723-4151 Ext. 1334 VM 602-817-6715	NONE
SHERRI ASHBAUGH Sashbaugh@azdes.gov	2705 N 4TH STREET, SUITE A FLAGSTAFF, AZ 86004	300-F	928-773-4957 VM 602-817-6723	NONE
SUSAN BICKERSTETH Sbickersteth@azdes.gov	2200 N CENTRAL, SUITE 207 PHOENIX, AZ 85004	795-M	602-817-6718	NONE
TANA COLEMAN Tcoleman@azdes.gov	2200 N CENTRAL, SUITE 207 PHOENIX, AZ 85004	795-M	602-817-6719	NONE

APPENDIX C:

PRIOR AUTHORIZATION (PA) FORMS

I.H.S. DIAPER/BRIEF ORDER FORM

CHOOSE ONE TYPE , AND THE NUMBER OF DIAPERS USED PER DAY

- PAMPERS, NB (10lbs) _____ # Used per Day _____
- PAMPERS, #1 (8-14 lbs) _____ # Used per Day _____
- PAMPERS #2 (12-18 lbs) _____ # Used per Day _____
- PAMPERS #3 (16-28lbs) _____ # Used per Day _____
- PAMPERS #4 (22-37 lbs) _____ # Used per Day _____
- PAMPERS #5 (27+ lbs) _____ # Used per Day _____
- PAMPERS #6 _____ # Used per Day _____

- PULL-UPS GN, S/M BOYS _____ # Used per Day _____
- PULL-UPS GN, S/M GIRLS _____ # Used per Day _____
- PULL-UPS GN, Lg/XL BOYS _____ # Used per Day _____
- PULL-UPS GN, Lg/XL GIRLS _____ # Used per Day _____
- PULL-UPS ALL NIGHT MED. _____ # Used per Day _____
- PULL-UPS ALL NIGHT Lg/XL _____ # Used per Day _____

- PULL-UP PROTECTION +, SMALL _____ # Used per Day _____
- PULL-UP PROTECTION +, MED _____ # Used per Day _____
- PULL-UP PROTECTION + _____ # Used per Day _____

TAB TYPE

- BRIEFS, YOUTH FULL FIT (15-22in) _____ # Used per Day _____
- BRIEFS, SMALL STAY DRY (20-31in) _____ # Used per Day _____
- BRIEFS, SMALL MOLICARE (20-30in) _____ # Used per Day _____
- BRIEFS, MED NU-FIT (32-44in) _____ # Used per Day _____
- BRIEFS, MED, MOLICARE (27-50in) _____ # Used per Day _____
- BRIEFS, LARGE, NU-FIT (45-58in) _____ # Used per Day _____
- BRIEFS, LARGE MOLICARE (43-64in) _____ # Used per Day _____
- BRIEFS, X-LARGE NU-FIT (45-58in) _____ # Used per Day _____

DRAFT
PAGE ONE

Diaper Request/DDD IHS ONLY

Covered benefit only ages 3 to 21!!!

Fax completed information to DES/DDD prior Authorization at Fax # 602-253-9083

Or Mail to :

DDD Health Care Services, 2200 North Central Ave. , Suite 506 Phx. AZ 85004

Date: _____ Support Coordinator/Case Worker: _____

Phone: _____ Fax: _____

Members Name: _____ Date of Birth: _____

Home Address: _____ Home Phone: _____

_____ AHCCCS #: _____

DDD Diagnosis: _____ HT. _____ WT. _____ ICD-9 CODE _____

Shipping Address: _____

(Note: Diapers cannot be shipped to a P.O. Box Address)

- Please Send:
- Page 2 (filled out)
 - Physician Order
 - Disability DX resulting in incontinence
 - ISP Decision Date _____

Support Coordinator Signature: _____

*****PRIOR AUTHORIZATION DEPARTMENT USE ONLY*****

Provider: _____ Prov ID # 155128 Auth Number _____

Total # of Diapers Authed _____ Cost Per Diaper _____

Code # _____ Start Date: _____ Expiration Date: _____

PA Nurse Signature _____ Date ___/___/___ Time _____

Mail Claims To:
DES/DDD
P.O. BOX 6123
SITE CODE 791A
ATTENTION: DDD CLAIMS
Phoenix AZ. 85005-6123

HEALTH CARE SERVICES
INSTRUCTIONS FOR COMPLETING THE DIAPER REQUEST FORM FOR
DDD/LTC I.H.S. CONSUMERS
PRIOR AUTHORIZATION FAX NUMBER IS 602-253-9083

**THESE FORMS ARE ONLY FOR DDD/LTC I.H.S. CONSUMERS.
IF YOUR CONSUMER HAS ANOTHER HEALTH PLAN, PLEASE CONTACT
THAT HEALTH PLAN FOR DIAPERS.**

CONSUMERS MUST BE BETWEEN THE AGES OF 3-21 YEARS OF AGE AND MUST BE DDD/LTC I.H.S. IN ORDER FOR THE DDD/LTC I.H.S. PRIOR AUTHORIZATION UNIT TO FILL THE REQUEST.

The following information is to help you know what information you need to put on each line of the diaper request form.

Page 1 of Diaper Request Form

DATE = Date you requested diapers

SUPPORT COORDINATOR/CASE WORKER= please put your full name

PHONE # = Your phone number and extension **FAX #** =your fax number

MEMBERS NAME= full name of Consumer **DOB** = Date of Birth of Consumer

HOME ADDRESS= Consumer's address **PHONE** = Consumer's home phone

DDD/LTC DIAGNOSIS= must be one of the following: SEIZURES, CP, AUTISM, COGNITIVE DISABILITY OR AT RISK [0-6].

If possible give the following information: (very important for proper fit!)

HT = height of member **WT** = weight of member

ICD-9 CODE= The doctor can put this code on the script

SHIPPING ADDRESS – IT IS MOST IMPORTANT YOU GIVE AN ADDRESS WHERE THE DIAPERS ARE TO BE SHIPPED TO.

DIAPERS CANNOT BE SHIPPED TO A PO BOX!

DDD/LTC I.H.S. MUST ALSO BE GIVEN THE FOLLOWING INFORMATION :

- 1. PAGE TWO FILLED OUT WITH NUMBER OF DIAPERS USED PER DAY.**
 - **Cannot exceed 8 diapers a day, which totals 240 per month**
- 2. A PHYSICIAN ORDER WITH MEDICAL JUSTIFICATION FOR USE OF DIAPERS [I.E. DUE TO COGNITIVE DISABILITY- CONSUMER IS UNABLE TO BE POTTY TRAINED].**
- 3. ISP DECISION DATE**

SUPPORT COORDINATOR SIGNATURE = PLEASE SIGN YOUR FULL NAME

****PLEASE USE GREAT CARE IN CHOOSING THE CORRECT SIZE. OUR PROVIDER PAYS FOR THE SHIPPING. INCORRECT DIAPER SIZES CANNOT BE RETURNED, NOR CAN THEY BE REPLACED WITH A NEW SIZE UNTIL THE NEXT SHIPMENT DUE DATE.****

**AUTHORIZATION REQUEST
FOR
INCONTINENCE BRIEFS**

Fax to: (602) 253-9083

DDD/LTC IHS

MEMBER INFORMATION

Name:	DOB:	AHCCCS ID# :
Other Insurance: <input type="checkbox"/> Medicare <input type="checkbox"/> Private Insurance: _____		
To ensure proper sizing, please list Member's	Weight (lbs): _____	Height (in): _____
		Waist (in): _____
Diagnosis: ICD-9 _____		(see requirements below)
Diagnosis Description:		
Please circle one answer for each of the following questions.		
1. Is the member currently incontinent?	Yes	No
2. If incontinent:	Urine only	Stool only
	Both	
3. How many briefs per day are needed? _____ If requesting more than 8 briefs per day, 240 per calendar month, a prescription to support medical necessity due to spastic colon and/or chronic diarrhea is required.		
4. Has the member ever been continent?	Yes	No
5. With proper training do you believe that the member will ever become continent of urine and/or stool	Yes	No

- Member must have documented proof of a disability, approved and/or covered medical condition that causes/contributes to incontinence of bowel and/or bladder.
- Maximum benefit limit is 240 briefs per calendar month. Member must be age 3 through 20 years of age to be eligible.
- I.H.S offers a select and limited line of incontinency briefs through a designated source.

Additional Information/Comments: _____

I certify that the above named DDD/LTC I.H.S. consumer is currently incontinent of urine and/or stool and that the incontinence is directly related to his/her disability. This certification is valid for a maximum 12 months and can be re-evaluated at that time.

PCP Signature PCP Name (Printed) Date

This transmission may contain information that is privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient, or an employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any disclosure, copying, distribution, or use of the information contained herein (including and reliance thereon) is STRICTLY PROHIBITED. If you received this transmission in error, please immediately contact the sender and destroy the material in its entirety, whether in electronic or hard copy format. Thank you.

I.H.S./VENT DDD/LTC EQUIPMENT AND SUPPLIES REQUISITION

FAX COMPLETED INFORMATION TO DES/DDD PRIOR AUTHORIZATION

IF MEMBER IS DDD/ I.H.S. FAX TO 602-253-9083

IF MEMBER IS ON VENT PROGRAM FAX TO 602 238-9294

PLEASE DO NOT MAIL REQUEST

In order to process an authorization, please complete top portion of this form

Date: _____ Support Coordinator _____

Phone Number _____ Fax Number _____

Member's Name: _____ Date of Birth _____

Deliver to: _____ Home Phone # _____

_____ AHCCCS ID # _____

DDD Diagnosis _____ ICD-9 CODE _____ Height _____ Weight _____

MEDICARE YES ___ NO ___ OTHER INSURANCE YES ___ NO ___ NAME _____

Policy Number _____ Insurance Phone Number _____

ITEM REQUESTED (only one item per request): _____

ITEM ACCESSORIES REQUESTED _____

THESE ITEMS MUST BE SENT:

- () Medical Justification (Can be obtained from Physician and/or Physical Therapist involved
- () Picture/Discription of Item requested () Physician Order/Prescription w/ date

PLEASE SEND THE FOLLOWING INFORMATION WHEN REQUIRED/REQUESTED:

() PT/OT Evaluation () DATE OF ISP Decision ____/____/____ SC Signature _____

*******PRIOR AUTHORIZATION DEPARTMENT USE ONLY*******

Date HCS Received request: _____

DDD/LTC Eligible Yes ___ No ___ CRS Yes ___ No ___ TPL - Yes ___ No ___ Medicare Yes ___ No ___

(1) Date Letter of Action sent _____ (2) Date Letter of Action sent _____ (3) Date Letter of Action sent _____

Accepted Provider _____ Phone Number _____

Prior Authorization # _____ () Faxed To _____ () Called To _____

Prior Authorization Nurse Signature _____ Date _____ Time _____

Mail Claims to:
DES/DDD
P.O. Box 6123
Site Code 791A
Attentin: DDD Claims
Phoenix AZ, 85005-6123

HEALTH CARE SERVICES HOW TO FILL OUT EQUIPMENT AND SUPPLIES FORM

The top of the form is to be filled out by the Support Coordinator or doctor's office. The needed information is listed on the top part of the form.

Until I.H.S. Prior Authorization Unit receives all of the information, we cannot complete the authorization process.

If the packet does not have all the information the PA Unit can not accept the packet and it will be returned to the SC to complet and resubmit for process.

Date = the date you fill out the form

Support Coordinator = Your full name

Phone Number = Your phone number

Fax Number = Your fax number

Consumer's name = Full name of Consumer

Date of Birth = date of birth of Consumer

Deliver to = Where the DME/Supplies are to be sent. **This cannot be a P.O. Box!**

Home Phone number = Consumer's phone number, or a number that can take a message for the parents/caregiver. Please write "message #" if it is a message phone number.

AHCCCS ID # = the Consumer's AHCCCS ID number

DDD Diagnosis = must be one of our accepted diagnoses: CP- SEIZURES- AUTISM- COGNITIVE DISABILITY- AT RISK [AGES 0 TO 6]

ICD-9 CODE= Ask the doctor to put this code on the script

Height = Consumer's height

Weight = Consumer's weight

Medicare = you must check to see if Consumer has Medicare. If so, mark "yes".

Other insurance = you must check to see if the Consumer has any other insurance [i.e. Cigna, Blue Cross] and if so, supply the information on the next two lines.

I.H.S. ONLY PAYS FOR WHAT MEDICARE OR OTHER INSURANCE DOES NOT COVER, SO WE NEED TO KNOW IF THE OTHER INSURANCE OR MEDICARE WILL COVER THE COST BEFORE WE GIVE AN AUTHORIZATION. THIS MAY DELAY THE PROCESS.

ALSO, IF THE SERVICE IS COVERED BY CRS, WE DO NOT PAY. IT IS IMPORTANT TO KNOW IF CRS WILL COVER THE ITEM BEFORE I.H.S. CAN GIVE AN AUTHORIZATION. PLEASE CHECK WITH CRS IF THIS IS A CRS COVERED SERVICE

Item Requested = ONLY give ONE item per page [i.e. Electric Wheel Chair; shower chair; suction machine].

Item Accessories Requested = anything that would go with the item requested
Example: **Item:** Suction Machine. **Item Accessories:** 8F suction caths, 2 per day, suction tubing, filters for suction machine 2 per month.

The following area is most important and the process cannot proceed if any item listed below is not in the packet you send.

The following items MUST be sent to us:

1. Medical justification [this can come from a doctor, or a Physical Therapist involved with Consumer]. There must be a current date [within the last 3 months] on the letter.
2. A picture and/or description of the requested item.
3. Physician Order/Prescription. There must be a current date [within the last 3 months].

We may need a PT/OT evaluation, so if you have one, send it. If not, and we need it, we cannot proceed until it is sent.

We do not always need the ISP date of decision; however, if you have it, please give it.

The SC must sign with full first and last name.

Once the claim has been approved and the provider has been given the Authorization number, we at PA have no control over how long it will take to get the item. The PA unit will make calls to the provider in hopes to find out what date the item was sent to the consumer.

**Fax the information for I.H.S. non -VENT consumer to 602-253-9083,
OR if consumer is in the VENT program, and the item is covered by the vent program fax to 602-238-9294.**

If you have any questions, please feel free to call me:

Jeanette Grissom RN

Medical Services/PA Supervisor

602-238-9028 Ext. 6034

1/18/08jg

I.H.S. INPATIENT
DES/DDD PRIOR AUTHORIZATION REQUEST
PHONE # 602-238-9028 FAX # 602-253-9083

IN ORDER TO PROCESS AN AUTHORIZATION THE FOLLOWING INFORMATION MUST BE FILLED IN

PLEASE SEND YOUR ADMIT FACE SHEET ALONG WITH THIS REQUEST

REQUEST DATE ___/___/___ PERSON REQUESTING PA _____
PHONE # _____ FAX # _____
PATIENT NAME _____ DOB ___/___/___ AHCCCS ID # _____
CRS COVERED ___ YES ___ NO OTHER INSURANCE INFO _____
FACILITY NAME _____ AHCCCS ID # _____
FACILITY ADDRESS _____
ADMIT DATED ___/___/___ ADMIT TIME _____ D/C DATED ___/___/___ D/C TIME _____
ADMIT DOCTOR _____ DOCTOR'S AHCCCS ID # _____
ADMITTED FROM (i.e. home ED, facility) _____
ADMITTED TO (Room#, ICU, PEDS) _____
BILLING/REVENUE CODE[S] _____
UNIT PHONE # _____ UR DEPT/RN _____ PHONE # _____
DIAGNOSIS _____ ICD9-CODE _____ DIAGNOSIS _____ ICD-9CODE _____
DIAGNOSIS _____ ICD-9 CODE _____ DIAGNOSIS _____ ICD-9 CODE _____

PLEASE FAX THE ABOVE INFORMATION TO DES/DDD FAX # 602-253-9083

FOR PRIOR AUTHORIZATION DEPARTMENT ONLY

ELIGIBLE ___ YES ___ NO RBHA ___ YES ___ NO CRS ___ YES ___ NO
TPL ___ YES ___ NO MEDICARE ___ YES ___ NO
DATE OF REFERENCE TO CRS ___/___/___ DATE OF CRS RESPONSE ___/___/___
AUTHORIZATION # _____ GIVEN TO _____ CALLED ___ FAXED ___
PA NURSE SIGNATIURE _____ DATE ___/___/___ TIME _____

MAIL CLAIMS TO:
DES/DDD
P.O. BOX 6123
SITE CODE 791A
PHOENIX, AZ 85000-6123
ATTENTION DDD CLAIMS

I.H.S. OFFICE/CLINIC VISITS
DES/DDD AUTHORIZATION REQUEST
PRIOR AUTHORIZATION PHONE # (602)238-9028 FAX # (602) 253-9083

Mail Claims To:
 DES/DDD
 P.O. BOX 6123
 SITE CODE 791A
 PHOENIX, AZ 85005-6123
 ATTENTION DDD CLAIMS

IN ORDER TO PROCESS AN AUTHORIZATION THE FOLLOWING INFORMATION MUST BE PROVIDED

REQUEST DATE ___/___/___ PERSON REQUESTING PA _____

PHONE # _____ FAX # _____

PATIENT NAME _____ CRS COVERED () YES () NO
 () TRAUMA () INDUSTRIAL
 PATIENT AHCCCS ID # _____ DOB _____ () RBHA/PSHY

PROVIDER NAME: _____ PROVIDER AHCCCS ID # _____

PROVIDER ADDRESS: _____

REFERRING DOCTOR _____ PHONE # _____

DIAGNOSIS DESCRIPTION _____ ICD-9 CODE _____

MEDICAL NECESSITY FOR VISIT _____

BILLING CODE	MODIFIER CODE	DESCRIPTION	DOS
_____	_____	_____	___/___/___
_____	_____	_____	___/___/___

PLEASE FAX THE ABOVE INFORMATION TO DES/DDD PA DEPARTMENT (FAX #: 602-253-9083)

AUTHORIZATION DEPARTMENT ONLY

ELIGIBLE ___ YES ___ NO RBHA ___ YES ___ NO CRS ___ YES ___ NO

DATE REFERRED TO CRS ___/___/___

CRS RESPONSE DATE ___/___/___ THEY: ___ APPROVED ___ DENIED

SENT TO MEDICAL DIRECTOR FOR REVIEW DATE ___/___/___ FAX ___ E-MAIL

MEDICAL DIRECTORS RESPONSE ___/___/___ ___ APPROVED ___ DENIED

DATE LETTER OF ACTION SENT ___/___/___

AUTHORIZATION # _____ GIVEN TO _____ CALLED ___ FAXED

PA NURSE SIGNATURE _____ DATE ___/___/___ TIME _____

DES/DDD I.H.S. OUTPATIENT/INPATIENT PROCEDURE

DES/DDD AUTHORIZATION REQUEST

PA DEPARTMENT PHONE # 602-238-9028 Ex. 6036 FAX # 602-253-9083

TO PROCESS AUTHORIZATION THE FOLLOING INFORMATION MUST BE FILLED IN

REQUEST DATED ___/___/___ CONTACT PERSON _____

PHONE # _____ FAX # _____

MEMBERS NAME _____ DOB ___/___/___

PATIENT AHCCCS ID# _____ CRS COVERED SERVICE ___YES___NO

PROVIDER NAME _____ PROVIDER AHCCCS # _____

DIAGNOSIS _____ ICD-9 CODE _____

DIAGNOSIS _____ ICD-9 CODE _____

BILLING CODE	MODIFIER CODE	DESCRIPTION	DOS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

AUTHORIZATION DEPARTMENT ONLY

ELIGIBLE ___YES___NO CRS ___YES___NO RBHA ___YES___NO TPL _____

AUTHORIZAION # _____ GIVEN TO _____ CALLED ___ FAXED ___

PA NURSE SIGNATURE _____ DATE ___/___/___ TIME _____

MAIL CLAIMS TO
DES/DDD
P.O. BOX 6123
SITE CODE 791A
ATTENTION: DDD CLAIMS
PHOENIX AZ. 85005-6123

APPENDIX D:
PREHOSPITAL MEDICAL CARE DIRECTIVE
(ADVANCE DIRECTIVE)
SAMPLE FORM

PREHOSPITAL MEDICAL CARE DIRECTIVE

SIDE ONE

(By A.R.S. 36-3251.B this form must be printed on orange paper.)

I refuse the following: (check only those treatments you refuse)

- 1. Chest compression
- 2. Defibrillation
- 3. Assisted ventilation
- 4. Intubation
- 5. Advanced life support medications

SAMPLE COPY

Patient: _____
patient's signature or mark

Date: _____

Attach recent photograph here or provide all of the following information below:

Date of Birth _____

Sex _____

Eye Color _____ Hair Color _____

Race _____

Hospice Program (if any) _____

RECENT PHOTOGRAPH

Name and telephone number of patient's physician

SAMPLE COPY

both sides must be completed!

PREHOSPITAL MEDICAL CARE DIRECTIVE
SIDE TWO

I have explained this form and its consequences to the signer and obtained assurance that the signer understands that death may result from any refused care checked above or on Side One of this form.

Licensed health care provider

Date _____

SAMPLE COPY

I was present when this was signed (or marked). The patient then appeared to be of sound mind and free from duress.

Witness

SAMPLE COPY

both sides must be completed!

APPENDIX E:

ADAPTIVE AIDS LIST

Durable Medical Equipment/Adaptive Aids Table

Durable medical equipment and adaptive aids must be medically necessary and prescribed by the PCP, or other provider upon referral by the PCP. Documentation from physician and therapist must establish the need for the equipment, the risk to the member without the equipment, and include a comprehensive explanation of how the member will benefit from the equipment. Covered durable medical equipment and adaptive aids should not duplicate existing equipment provided to the member.

The Division has developed criteria for approval of high frequency chest wall oscillation vests and enclosed/restraint beds, which may be requested by contacting your Provider Relations Representative.

Covered adaptive aids are limited to:

1. Traction equipment
2. Feeding aids, including trays for wheelchairs and adapted feeding utensils
3. Helmets
4. Stenders, prone and upright
5. Toileting aids, including bedpans and urinals for bed bound members, commodes
6. Bathing aids, including shower chairs, bath chairs, portable baths, hand-held shower heads
7. Incontinence supplies for members (3) years and through age 20. There is a limit of 240 briefs per month per DD/ALTCS eligible member unless the prescribing physician provides evidence of medical necessity for more than 240 briefs per month for a member diagnosed with chronic diarrhea or spastic bowel.
8. Wedges for positioning
9. Transfer aids including portable lifts, such as Hoyer, Voyager, Trixie. When determined medically necessary as part of a DES/DDD approved environmental modification, Subcontractor is responsible to provide the recommended lift and DES/DDD will provide the non-portable tracking system and non-portable tracking system installation.
10. Grab bars, i.e. shower and toilet, including installation
11. Car seats required for transport due to the physical condition of the member which considers head and trunk control, airway obstruction potential, presence of potential for scoliosis, and/or presence of seizure activity
12. Other items determined to be medically necessary by joint consultation of the Medical Directors of Subcontractor and DES/DDD.

APPENDIX F:
CRS REFERRAL FORM

**ARIZONA DEPARTMENT OF
HEALTH SERVICES
CHILDREN'S REHABILITATIVE
SERVICES (CRS)**

Please send this form to the clinic nearest you:
 124 W. Thomas Rd., Phoenix, AZ 85013 (800) 392-2222 Tel-(602) 406-5731 or Fax-(602) 406-7166
 2600 N. Wyatt Dr., Tucson, AZ 85712 (800) 231-8261 Tel-(520) 324-5437 or Fax-(520) 324-3233
 1200 N. Beaver, Flagstaff, AZ 86001 (800) 232-1018 Tel-(928) 773-2054 or Fax-(928) 773-2286
 2400 Avenue A, Yuma, AZ 85364 (800) 837-7309 Tel-(928) 336-7095 or Fax-(928) 336-7497

CRS APPLICATION FORM

TODAY'S DATE:

CHILD'S NAME (Last, First, Middle)		RACE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH (mo/day/yr) / /	
PARENT OR GUARDIAN (Last Name, First Name)			RELATIONSHIP TO CHILD <input type="checkbox"/> Natural Parent (s) <input type="checkbox"/> Adoptive <input type="checkbox"/> Foster <input type="checkbox"/> Other		
CHILD'S ADDRESS	STREET	CITY	STATE	ZIP CODE	COUNTY
					US Citizen Yes or No
HOME TELEPHONE ()-	MESSAGE /CELL PHONE NUMBER ()-		WORK PHONE NUMBER ()-	E-MAIL ADDRESS	
IN EMERGENCY NOTIFY (Name, Relationship, Address, Telephone)					
CHILD'S Primary Care Practitioner		ADDRESS		PHONE NUMBER	
REFERRED BY: (Name, address, phone) (This individual verifies that the child's parent/guardian has been notified about this referral.)					
REASON FOR REFERRAL TO CRS:					
LIST PRIMARY DIAGNOSES (e.g., Cleft Lip, VSD, Cerebral Palsy, etc.) IF AVAILABLE, PLEASE SEND RECORDS WITH THIS FORM.					
1)			4)		
2)			5)		
3)			6)		
LIST ANY KNOWN ALLERGIES					
1)	2)	3)	4)		
HAS CHILD RECEIVED CRS SERVICES BEFORE?:		YEAR?	WHERE?	PRIMARY LANGUAGE?	
		<input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME OF PERSON WHO COMPLETED THIS FORM		ADDRESS	PHONE ()-	RELATIONSHIP TO PATIENT	

PERMISSION TO OBTAIN RECORDS

I hereby authorize and request the CHILDREN'S REHABILITATIVE SERVICES through the authorized contractors, to request and obtain photocopies of medical records concerning the above named patient:

Obtain records from:

Primary Care Practitioner _____ Address: _____

Specialist: _____ Address: _____

Specialist: _____ Address: _____

Therapist/Education: _____ Address: _____

This consent will expire one year after the signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify the Children's Rehabilitative Services clinic in writing to that effect. I understand that a photocopy or facsimile of this authorization is considered acceptable in lieu of the original.

Signature of Consenting Party Date Relationship to Patient

AHCCCS PLAN [] YES [] NO HEALTH INSURANCE [] YES [] NO *Please include copy of insurance information or card.*

FOR CRS CLINIC USE ONLY				
APPLICATION REVIEWED BY:			DATE	<input type="checkbox"/> Approved
SPECIALTY CLINIC ASSIGNMENTS:				
<input type="checkbox"/> PEND- diagnostic tests	<input type="checkbox"/> PEND- waiting for medical documentation	<input type="checkbox"/> DENY- no medical documentation	<input type="checkbox"/> DENY-not medically eligible	<input type="checkbox"/> DENY - Other reason

APPENDIX G:
EPSDT PERIODICITY SCHEDULE
AND
EPSDT FORMS

EXHIBIT 430-1

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

**EXHIBIT 430-1
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
EPSDT PERIODICITY SCHEDULE**

PROCEDURES	INFANCY								EARLY CHILDHOOD				MIDDLE CHILDHOOD			ADOLESCENCE	
	new born	2-4 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	8 yr	Annually 10 -- 20 years of age
History Initial/Interval	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Height & Weight, including Body Mass Index (BMI) for those 24 months and older	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Head Circumference	x	x	x	x	x	x	x	x	x	x	x						
Blood Pressure – PCP should assess the need for B/P measurement for children birth to 24 months	+	+	+	+	+	+	+	+	+	+	+	x	x	x	x	x	x
Nutritional Assessment	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Vision	SEE SEPARATE SCHEDULE																
Hearing/Speech	SEE SEPARATE SCHEDULE																
Dev./Behavioral Assess.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Physical Examination	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Immunization	SEE SEPARATE SCHEDULE																
Tuberculin Test								+	+	+	+	+	+	+	+	+	+
Hematocrit/Hemoglobin								x →	+								← +13 →
Urinalysis														x			← +16 →
Lead Screen /Verbal						x	x		x	x		x	x	x	x		
Lead Screen/Blood Test								x			x	x*	x*	x*	x*		
Anticipatory Guidance	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Dyslipidemia Screening											x		x		x	x	x
Dislipidemia Testing																	x (one time testing between 18 and 20 years of age)
STI Screening																	x (risk assessment for those 11-20)
Cervical Dysplasia Screening																	x (risk assessment for those 11-20)
Dental Referral								+	+	+	+	+	+	x	x	x	x

These are minimum requirements. If at any time other procedures, tests, etc. are medically indicated, the physician is obligated to perform them. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

- Key: x = to be completed
 + = to be performed for members at risk when indicated
 ← x → = the range during which a service may be provided, with the x indicating the preferred age
 * = Members not previously screened who fall within this range (36 to 72 months of age) must have a blood lead screen performed

NOTE: If American Academy of Pediatrics guidelines are used for the screening schedule and/or more screenings are medically necessary, those additional interperiodic screenings will be covered.

NOTE: The American Association of Pediatric Dentistry recommends that dental visits begin by age one (1). PCP referrals for dental care are mandatory beginning at three (3) years of age. Referrals should be encouraged by one (1) year of age. Parents of young children may self refer to a dentist within the Contractor's network at any time.

EXHIBIT 430-1 (con't)

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

Procedure	MONTHS OF AGE											YEARS OF AGE																	
	New born	2 - 4 Days	by 1 mo	2	4	6	9	12	15	18	24	3*	4	5	6	8	10	11	12	13	14	15	16	17	18	19 through 20 years of age			
Vision +	S	S	S	S	S	S	S	S	S	S	S	O	O	O	O	O	O	S	O	S	S	O	S	S	O	S	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 patient is uncooperative, rescreen in 6 months.
+ = May be done more frequently if indicated or at increased risk.

Revised: 4/1/2007, 8/1/2005

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
HEARING AND SPEECH PERIODICITY SCHEDULE**

Procedure	MONTHS OF AGE													YEARS OF AGE														
	New born	2 - 4 days	2 weeks	By 1 mo	6 weeks	2	4	6	9	12	15	18	24	3	4	5	6	8	10	11	12	13	14	15	16	17	18	Through 20 years of age
Hearing/ Speech+	O**	S	O**			S	S	S	S	S	S	S	S	S	O	O	O	O	O	S	O	S	S	O	S	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
***** = 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: 4/1/2007, 8/1/2005

EXHIBIT 430-1A

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

Exhibit 430-1A

AHCCCS Dental Periodicity Schedule

RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC ORAL HEALTH CARE*					
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.					
	AGE	12-24 months	2-6 years	6-12 years	12 years and older
Clinical oral examination including but not limited to the following: ¹		X	X	X	X
➤ Assess oral growth and development		X	X	X	X
➤ Caries-risk Assessment		X	X	X	X
➤ Assessment for 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 fluoride		X	X	X	X

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

Note: Parents or caregivers should be included in all consultations and counseling of members regarding preventive oral health care and the clinical findings.

Note: 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.

* Adaptation from the American Academy of Pediatric Dentistry Schedule

Initial Effective Date: 10/01/08

EXHIBIT 430-2

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
RECOMMENDED CHILDHOOD AND ADOLESCENT
IMMUNIZATION SCHEDULES**

Recommended Immunization Schedule for Persons Aged 0 Through 6 Years—United States • 2009

For those who fall behind or start late, see the catch-up schedule

Vaccine ▼	Age ►	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years	
Hepatitis B ¹	HepB	HepB	HepB		<i>see footnote 1</i>	HepB							Range of recommended ages
Rotavirus ²	RV		RV	RV	RV ²								
Diphtheria, Tetanus, Pertussis ³	DTaP		DTaP	DTaP	DTaP	<i>see footnote 3</i>	DTaP						Certain high-risk groups
<i>Haemophilus influenzae</i> type b ⁴	Hib		Hib	Hib	Hib ⁴		Hib						
Pneumococcal ⁵	PCV		PCV	PCV	PCV		PCV				PPSV		
Inactivated Poliovirus	IPV		IPV	IPV			IPV					IPV	
Influenza ⁶	Influenza (Yearly)												
Measles, Mumps, Rubella ⁷	MMR						MMR			<i>see footnote 7</i>		MMR	
Varicella ⁸	Varicella						Varicella			<i>see footnote 8</i>		Varicella	
Hepatitis A ⁹	HepA (2 doses)										HepA Series		
Meningococcal ¹⁰	MCV										MCV		

This schedule indicates the recommended ages for routine administration of currently licensed vaccines, as of December 1, 2008, for children aged 0 through 6 years. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. Licensed combination vaccines may be used whenever any component of the combination is indicated and other components are not contraindicated and if approved by the Food and Drug Administration for that dose of

the series. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations, including high-risk conditions: <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967.

1. Hepatitis B vaccine (HepB). (Minimum age: birth)

At birth:

- Administer monovalent HepB to all newborns before hospital discharge.
- If mother is hepatitis B surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
- If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine mother's HBsAg status as soon as possible and, if HBsAg-positive, administer HBIG (no later than age 1 week).

After the birth dose:

- The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1 or 2 months. The final dose should be administered no earlier than age 24 weeks.
- Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg (anti-HBs) after completion of at least 3 doses of the HepB series, at age 9 through 18 months (generally at the next well-child visit).

4-month dose:

- Administration of 4 doses of HepB to infants is permissible when combination vaccines containing HepB are administered after the birth dose.

2. Rotavirus vaccine (RV). (Minimum age: 6 weeks)

- Administer the first dose at age 6 through 14 weeks (maximum age: 14 weeks 6 days). Vaccination should not be initiated for infants aged 15 weeks or older (i.e., 15 weeks 0 days or older).
- Administer the final dose in the series by age 8 months 0 days.
- If Rotarix[®] is administered at ages 2 and 4 months, a dose at 6 months is not indicated.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). (Minimum age: 6 weeks)

- The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.
- Administer the final dose in the series at age 4 through 6 years.

4. Haemophilus influenzae type b conjugate vaccine (Hib). (Minimum age: 6 weeks)

- If PRP-OMP (PedvaxHIB[®] or Comvax[®] [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
- TriHiBit[®] (DTaP/Hib) should not be used for doses at ages 2, 4, or 6 months but can be used as the final dose in children aged 12 months or older.

5. Pneumococcal vaccine. (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])

- PCV is recommended for all children aged younger than 5 years.
- Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.

- Administer PPSV to children aged 2 years or older with certain underlying medical conditions (see *MMWR* 2000;49[No. RR-9]), including a cochlear implant.

6. Influenza vaccine. (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])

- Administer annually to children aged 6 months through 18 years.
- For healthy nonpregnant persons (i.e., those who do not have underlying medical conditions that predispose them to influenza complications) aged 2 through 49 years, either LAIV or TIV may be used.
- Children receiving TIV should receive 0.25 mL if aged 6 through 35 months or 0.5 mL if aged 3 years or older.
- Administer 2 doses (separated by at least 4 weeks) to children aged younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.

7. Measles, mumps, and rubella vaccine (MMR). (Minimum age: 12 months)

- Administer the second dose at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 28 days have elapsed since the first dose.

8. Varicella vaccine. (Minimum age: 12 months)

- Administer the second dose at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 3 months have elapsed since the first dose.
- For children aged 12 months through 12 years the minimum interval between doses is 3 months. However, if the second dose was administered at least 28 days after the first dose, it can be accepted as valid.

9. Hepatitis A vaccine (HepA). (Minimum age: 12 months)

- Administer to all children aged 1 year (i.e., aged 12 through 23 months). Administer 2 doses at least 6 months apart.
- Children not fully vaccinated by age 2 years can be vaccinated at subsequent visits.
- HepA also is recommended for children older than 1 year who live in areas where vaccination programs target older children or who are at increased risk of infection. See *MMWR* 2006;55[No. RR-7].

10. Meningococcal vaccine. (Minimum age: 2 years for meningococcal conjugate vaccine [MCV] and for meningococcal polysaccharide vaccine [MPSV])

- Administer MCV to children aged 2 through 10 years with terminal complement component deficiency, anatomic or functional asplenia, and certain other high-risk groups. See *MMWR* 2005;54[No. RR-7].
- Persons who received MPSV 3 or more years previously and who remain at increased risk for meningococcal disease should be revaccinated with MCV.

Recommended Immunization Schedule for Persons Aged 7 Through 18 Years—United States • 2009

For those who fall behind or start late, see the schedule below and the catch-up schedule

Vaccine ▼	Age ►	7–10 years	11–12 years	13–18 years
Tetanus, Diphtheria, Pertussis ¹		see footnote 1	Tdap	Tdap
Human Papillomavirus ²		see footnote 2	HPV (3 doses)	HPV Series
Meningococcal ³		MCV	MCV	MCV
Influenza ⁴		Influenza (Yearly)		
Pneumococcal ⁵		PPSV		
Hepatitis A ⁶		HepA Series		
Hepatitis B ⁷		HepB Series		
Inactivated Poliovirus ⁸		IPV Series		
Measles, Mumps, Rubella ⁹		MMR Series		
Varicella ¹⁰		Varicella Series		

Range of recommended ages

Catch-up immunization

Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed vaccines, as of December 1, 2008, for children aged 7 through 18 years. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. Licensed combination vaccines may be used whenever any component of the combination is indicated and other components are not contraindicated and if approved by the Food and Drug Administration for that dose of

the series. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations, including high-risk conditions: <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967.

1. Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap). (Minimum age: 10 years for BOOSTRIX® and 11 years for ADACEL®)

- Administer at age 11 or 12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a tetanus and diphtheria toxoid (Td) booster dose.
- Persons aged 13 through 18 years who have not received Tdap should receive a dose.
- A 5-year interval from the last Td dose is encouraged when Tdap is used as a booster dose; however, a shorter interval may be used if pertussis immunity is needed.

2. Human papillomavirus vaccine (HPV). (Minimum age: 9 years)

- Administer the first dose to females at age 11 or 12 years.
- Administer the second dose 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).
- Administer the series to females at age 13 through 18 years if not previously vaccinated.

3. Meningococcal conjugate vaccine (MCV).

- Administer at age 11 or 12 years, or at age 13 through 18 years if not previously vaccinated.
- Administer to previously unvaccinated college freshmen living in a dormitory.
- MCV is recommended for children aged 2 through 10 years with terminal complement component deficiency, anatomic or functional asplenia, and certain other groups at high risk. See *MMWR* 2005;54(No. RR-7).
- Persons who received MPSV 5 or more years previously and remain at increased risk for meningococcal disease should be revaccinated with MCV.

4. Influenza vaccine.

- Administer annually to children aged 6 months through 18 years.
- For healthy nonpregnant persons (i.e., those who do not have underlying medical conditions that predispose them to influenza complications) aged 2 through 49 years, either LAIV or TIV may be used.
- Administer 2 doses (separated by at least 4 weeks) to children aged younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.

5. Pneumococcal polysaccharide vaccine (PPSV).

- Administer to children with certain underlying medical conditions (see *MMWR* 1997;46[No. RR-8]), including a cochlear implant. A single revaccination should be administered to children with functional or anatomic asplenia or other immunocompromising condition after 5 years.

6. Hepatitis A vaccine (HepA).

- Administer 2 doses at least 6 months apart.
- HepA is recommended for children older than 1 year who live in areas where vaccination programs target older children or who are at increased risk of infection. See *MMWR* 2006;55(No. RR-7).

7. Hepatitis B vaccine (HepB).

- Administer the 3-dose series to those not previously vaccinated.
- A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB® is licensed for children aged 11 through 15 years.

8. Inactivated poliovirus vaccine (IPV).

- For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if the third dose was administered at age 4 years or older.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

9. Measles, mumps, and rubella vaccine (MMR).

- If not previously vaccinated, administer 2 doses or the second dose for those who have received only 1 dose, with at least 28 days between doses.

10. Varicella vaccine.

- For persons aged 7 through 18 years without evidence of immunity (see *MMWR* 2007;56[No. RR-4]), administer 2 doses if not previously vaccinated or the second dose if they have received only 1 dose.
- For persons aged 7 through 12 years, the minimum interval between doses is 3 months. However, if the second dose was administered at least 28 days after the first dose, it can be accepted as valid.
- For persons aged 13 years and older, the minimum interval between doses is 28 days.

The Recommended Immunization Schedules for Persons Aged 0 Through 18 Years are approved by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).

DEPARTMENT OF HEALTH AND HUMAN SERVICES • CENTERS FOR DISEASE CONTROL AND PREVENTION

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 • 2009

The table 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.

CATCH-UP SCHEDULE FOR PERSONS AGED 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)		
Rotavirus ²	6 wks	4 weeks	4 weeks ²		
Diphtheria, Tetanus, Pertussis ³	6 wks	4 weeks	4 weeks	6 months	6 months ³
<i>Haemophilus influenzae</i> type b ⁴	6 wks	4 weeks if first dose administered at younger than age 12 months 8 weeks (as final dose) if first dose administered at age 12-14 months No further doses needed if first dose administered at age 15 months or older	4 weeks ⁴ if current age is younger than 12 months 8 weeks (as final dose) ⁴ if current age is 12 months or older and second dose administered at younger than age 15 months No further doses needed if previous dose administered at age 15 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months	
Pneumococcal ⁵	6 wks	4 weeks if first dose administered at younger than age 12 months 8 weeks (as final dose for healthy children) if first dose administered at age 12 months or older or current age 24 through 59 months 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 8 weeks (as final dose for healthy children) if current age is 12 months or older 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 months through 59 months who received 3 doses before age 12 months or for high-risk children who received 3 doses at any age	
Inactivated Poliovirus ⁶	6 wks	4 weeks	4 weeks	4 weeks ⁶	
Measles, Mumps, Rubella ⁷	12 mos	4 weeks			
Varicella ⁸	12 mos	3 months			
Hepatitis A ⁹	12 mos	6 months			
CATCH-UP SCHEDULE FOR PERSONS AGED 7 THROUGH 18 YEARS					
Tetanus, Diphtheria/ Tetanus, Diphtheria, Pertussis ¹⁰	7 yrs ¹⁰	4 weeks	4 weeks if first dose administered at younger than age 12 months 6 months if first dose administered at age 12 months or older	6 months if first dose administered at younger than age 12 months	
Human Papillomavirus ¹¹	9 yrs	Routine dosing intervals are recommended ¹¹			
Hepatitis A ⁹	12 mos	6 months			
Hepatitis B ¹	Birth	4 weeks	8 weeks (and at least 16 weeks after first dose)		
Inactivated Poliovirus ⁶	6 wks	4 weeks	4 weeks	4 weeks ⁶	
Measles, Mumps, Rubella ⁷	12 mos	4 weeks			
Varicella ⁸	12 mos	3 months if the person is younger than age 13 years 4 weeks if the person is aged 13 years or older			

1. Hepatitis B vaccine (HepB).

- Administer the 3-dose series to those not previously vaccinated.
- A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB[®] is licensed for children aged 11 through 15 years.

2. Rotavirus vaccine (RV).

- The maximum age for the first dose is 14 weeks 6 days. Vaccination should not be initiated for infants aged 15 weeks or older (i.e., 15 weeks 0 days or older).
- Administer the final dose in the series by age 8 months 0 days.
- If Rotarix[®] was administered for the first and second doses, a third dose is not indicated.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).

- The fifth dose is not necessary if the fourth dose was administered at age 4 years or older.

4. *Haemophilus influenzae* type b conjugate vaccine (Hib).

- Hib vaccine is not generally recommended for persons aged 5 years or older. No efficacy data are available on which to base a recommendation concerning use of Hib vaccine for older children and adults. However, studies suggest good immunogenicity in persons who have sickle cell disease, leukemia, or HIV infection, or who have had a splenectomy; administering 1 dose of Hib vaccine to these persons is not contraindicated.
- If the first 2 doses were PRP-OMP (PedvaxHib[®] or Comvax[®]), and administered at age 11 months or younger, the third (and final) dose should be administered at age 12 through 15 months and at least 8 weeks after the second dose.
- If the first dose was administered at age 7 through 11 months, administer 2 doses separated by 4 weeks and a final dose at age 12 through 15 months.

5. Pneumococcal vaccine.

- Administer 1 dose of pneumococcal conjugate vaccine (PCV) to all healthy children aged 24 through 59 months who have not received at least 1 dose of PCV on or after age 12 months.
- For children aged 24 through 59 months with underlying medical conditions, administer 1 dose of PCV if 3 doses were received previously or administer 2 doses of PCV at least 8 weeks apart if fewer than 3 doses were received previously.
- Administer pneumococcal polysaccharide vaccine (PPSV) to children aged 2 years or older with certain underlying medical conditions (see *MMWR* 2000;49[No. RR-9]), including a cochlear implant, at least 8 weeks after the last dose of PCV.

6. Inactivated poliovirus vaccine (IPV).

- For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if the third dose was administered at age 4 years or older.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

7. Measles, mumps, and rubella vaccine (MMR).

- Administer the second dose at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 28 days have elapsed since the first dose.
- If not previously vaccinated, administer 2 doses with at least 28 days between doses.

8. Varicella vaccine.

- Administer the second dose at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 3 months have elapsed since the first dose.
- For persons aged 12 months through 12 years, the minimum interval between doses is 3 months. However, if the second dose was administered at least 28 days after the first dose, it can be accepted as valid.
- For persons aged 13 years and older, the minimum interval between doses is 28 days.

9. Hepatitis A vaccine (HepA).

- HepA is recommended for children older than 1 year who live in areas where vaccination programs target older children or who are at increased risk of infection. See *MMWR* 2006;55(No. RR-7).

10. Tetanus and diphtheria toxoids vaccine (Td) and tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).

- Doses of DTaP are counted as part of the Td/Tdap series
- Tdap should be substituted for a single dose of Td in the catch-up series or as a booster for children aged 10 through 18 years; use Td for other doses.

11. Human papillomavirus vaccine (HPV).

- Administer the series to females at age 13 through 18 years if not previously vaccinated.
- Use recommended routine dosing intervals for series catch-up (i.e., the second and third doses should be administered at 2 and 6 months after the first dose). However, the minimum interval between the first and second doses is 4 weeks. The minimum interval between the second and third doses is 12 weeks, and the third dose should be given at least 24 weeks after the first dose.

EPSDT STANDARDS AND TRACKING FORMS



AHCCCS EPSDT TRACKING FORMS

The AHCCCS EPSDT Tracking Forms must be used by providers to document all age-specific, required information related to EPSDT screenings and visits. Only the AHCCCS forms may be used; paper form substitutes are not acceptable. If Provider chooses to utilize an electronic EPSDT form, this electronic substitute will be acceptable provided the following conditions are met:

1. Provider's electronic form includes all fields that are present on the AHCCCS EPSDT form.
2. In the future AHCCCS may create an electronic EPSDT form. In that event, provider agrees to convert to AHCCCS electronic EPSDT form.

AHCCCS Contractors are required to make these forms available to their contracted providers. Interested persons may refer to Chapter 400 in this Manual for a discussion of EPSDT responsibilities and services.

A copy of the completed form signed by the clinician should be placed in the member's medical record.

If the member is enrolled with an AHCCCS Contractor, a copy of the completed and signed form must be sent to that Contractor.

If the patient is an AHCCCS fee-for-service member (e.g., enrolled in Indian Health Services), the provider should maintain a copy of the EPSDT tracking form in the medical record, but does not need to send a copy elsewhere.

AHCCCS Contractors and AHCCCS medical providers may reproduce the EPSDT forms as needed. All others may reproduce the forms with permission of the Arizona Health Care Cost Containment System. Written requests for the Tracking Forms may be directed to:

AHCCCS
Division of Health Care Management
CQM/Maternal and Child Health
701 E. Jefferson, Mail Drop 6500
Phoenix, AZ 85034
(602) 417-4410

NOTE: The Centers for Medicare and Medicaid Services require AHCCCS to provide specified services to our EPSDT population. These EPSDT Tracking Forms have been designed to ensure that needed services are performed, and that our members are provided an opportunity to receive preventive care. Please do NOT alter or amend these forms in any way without discussion with our Maternal and Child Health Manager at the address above.

Contact information for AHCCCS' subcontracted health care plans may be found at www.ahcccs.state.az.us.

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
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Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship
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NICU: <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS : <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS Pathway:	Allergies:	Temp:	Pulse:	Resp:
Medications:			Birth wt:	Wt:	%	Length:
			%	Head circ:	%	

Hospital Newborn Hearing Screen: ABR OAE: **Rt. ear** pass refer **Lt. ear** pass refer Unknown
Second Newborn Hearing Screen (if 2nd needed/completed): ABR OAE: **Rt. ear** pass refer **Lt. ear** pass refer Unknown

PARENTAL CONCERNS/HISTORY: How are you feeling about the baby? Do you feel safe in your home?

NUTRITIONAL SCREEN: INDICATES GUIDANCE GIVEN: Breast fed Formula: _____
 Cereal Adequate intake Supplements:

DEVELOPMENTAL SCREEN: INDICATES ACCOMPLISHMENT: Responds to sounds Responds to parent's voice Follows with eyes Awake for 1 hour stretches Beginning Tummy Time Play Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: INDICATES GUIDANCE GIVEN: Supine sleep Car seat/rear facing Infant bonding Bottle prop Support/who can help? Infant crying/what to do? Safe bathing/water temperature Shaken baby prevention Passive smoke Emergency/911 Sun safety Other

BEHAVIORAL HEALTH SCREEN: INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: Family Adjustment/parent responds positively to child Length of time infant cries Infant hands to mouth/self calming Encourage holding Other

COMPREHENSIVE PHYSICAL EXAM:

Skin/Hair/Nails		Lungs	
Eyes/Vision		Abdomen	
Ear		Genitourinary	
Mouth/Throat/Teeth		Extremities	
Nose/Head/Neck		Spine	
Heart		Neurological	

ASSESSMENT/PLAN/FOLLOW UP

INDICATES ORDERED 2nd Newborn screening (5 - 10 days of age or first PCP visit) Other

INDICATES ORDERED 1st Hepatitis B vaccine date: _____ Pt. Needs immunization today Shot record initiated 2nd Hepatitis B vaccine date: _____ Delayed/Deferred Parent refuses Other reason

INDICATES REFERRED CRS WIC ALTCS PT OT Speech AzEIP/DDD Developmental Behavioral Early Head Start Specialty 2nd Newborn hearing screen (if needed) Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note Yes No

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
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Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship
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NICU: <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS : <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS Pathway:	Allergies:	Temp:	Pulse:	Resp:		
Medications:		Birth wt:	Wt:	%	Length:	%	Head circ:	%

Risk indicators of hearing loss: yes no
 Hospital Newborn Hearing Screen: ABR OAE: Rt. ear pass refer Lt. ear pass refer Unknown
 Second Newborn Hearing Screen (if 2nd needed/completed): ABR OAE: Rt. ear pass refer Lt. ear pass refer Unknown

PARENTAL CONCERNS/HISTORY:

NUTRITIONAL SCREEN: INDICATES GUIDANCE GIVEN: Breast fed Formula: _____
 Cereal Adequate intake Supplements:

DEVELOPMENTAL SCREEN: INDICATES ACCOMPLISHMENT: Some Head Control Coos, babbles Makes Eye Contact
 Fixes/follows with eyes Begins imitation of movement and facial expressions Tummy Time/ lifts head, neck with forearm support Startles at loud noises Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: INDICATES GUIDANCE GIVEN: Supine sleep Car seat/rear facing Infant bonding Bottle prop Support/who can help? Infant crying/what to do Safe bathing/water temperature Shaken baby prevention Pacifiers Passive smoke Emergency/911 Sun safety Parent reads to child Other

BEHAVIORAL HEALTH SCREEN: INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: Family Adjustment/parent responds positively to child Length of time infant cries Infant hands to mouth/self calming Encourage holding Social smile Enjoys interacting with others Other

COMPREHENSIVE PHYSICAL EXAM:

Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

INDICATES ORDERED 2nd Newborn screening (if needed) Other

INDICATES ORDERED Pt. Needs immunization today Delayed/Deferred Parent refuses Other reason Hepatitis B DTaP Hib IPV PCV Rotavirus Other

INDICATES REFERRED CRS WIC ALTCS PT OT Speech AzEIP/DDD Developmental Behavioral Early Head Start Specialty Other

Date	Last Name	First Name	AHCCCS ID #	DOB
Primary Care Provider		PCP ph. #	Health Plan	Accompanied by (name)
				Relationship

NICU: <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS : <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS Pathway:	Birth Wt:	Allergies:			Temp:	Pulse:	Resp:
Risk indicators of hearing loss: <input type="checkbox"/> yes <input type="checkbox"/> no		Medications:		Wt:	%	Length:	%	Head circ:	%

PARENTAL CONCERNS/HISTORY:

NUTRITIONAL SCREEN: INDICATES GUIDANCE GIVEN: Breast fed Formula: _____
 Cereal Plan to introduce solids _____
 Soda/Juice Adequate intake Supplements: _____

DEVELOPMENTAL SCREEN: INDICATES ACCOMPLISHMENTS Babbles and coos Smiles Begins to roll front to back
 Pushes up with arms Controls head well Reaches for objects Interest in mirror images Pushes down with legs when feet on surface Looks at you with eyes Other _____

AGE APPROPRIATE EDUCATION AND GUIDANCE: INDICATES GUIDANCE GIVEN: Car seat/rear facing Emergency 911 Bottle prop Support/who can help? Infant crying/what to do? Safe bathing/water temperature Shaken baby prevention Establish daily routines/infant regulation Establish nighttime sleep routine/sleep through night=5 hours Introduce child temperament/easy/sensitive Passive smoke Parent reads to child Other _____

BEHAVIORAL HEALTH SCREEN: INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: Family Adjustment/Parent responds positively to baby Length of time infant cries Infant hands to mouth/self calming Smiles when hears parents' voice Encourage holding Easily distracted/excitement of discovery of outside world Other _____

COMPREHENSIVE PHYSICAL EXAM:

Skin/Hair/Nails		Lungs	
Eyes/Vision		Abdomen	
Ear		Genitourinary	
Mouth/Throat/Teeth		Extremities	
Nose/Head/Neck		Spine	
Heart		Neurological	

ASSESSMENT/PLAN/FOLLOW UP

	<input checked="" type="checkbox"/> INDICATES ORDERED <input type="checkbox"/>
	<input checked="" type="checkbox"/> INDICATES ORDERED <input type="checkbox"/> Pt. Needs immunization today <input type="checkbox"/> Delayed/Deferred <input type="checkbox"/> Parent refuses <input type="checkbox"/> Other reason <input type="checkbox"/> Hepatitis B <input type="checkbox"/> DTaP <input type="checkbox"/> Hib <input type="checkbox"/> IPV <input type="checkbox"/> PCV <input type="checkbox"/> Rotavirus <input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> INDICATES REFERRED <input type="checkbox"/> CRS <input type="checkbox"/> WIC <input type="checkbox"/> ALTCS <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Audiology <input type="checkbox"/> Speech <input type="checkbox"/> AzEIP/ DDD <input type="checkbox"/> Developmental <input type="checkbox"/> Early Head Start <input type="checkbox"/> Behavioral <input type="checkbox"/> Specialty <input type="checkbox"/> Other _____

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note Yes No

6 Months Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
Primary Care Provider		PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS : <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS Pathway:	Birth Wt:	Allergies:	Temp:	Pulse:	Resp:	
Risk indicators of hearing loss: <input type="checkbox"/> yes <input type="checkbox"/> no		Medications:	Wt:	%	Length:	%	Head circ:	%

PARENTAL CONCERNS/HISTORY:

VERBAL LEAD RISK ASSESSMENT: INDICATES GUIDANCE GIVEN: At risk yes no (if yes, a blood lead test is required)

NUTRITIONAL SCREEN: INDICATES GUIDANCE GIVEN: Adequate intake Breast fed Formula: _____
 Rice cereal Solids Soda/Juice Supplements:

DEVELOPMENTAL SCREEN: INDICATES ACCOMPLISHMENTS "Dada, baba" babbles Rolls over Transfers small objects
 Vocal imitation Sits with support Explores with hands and mouth Peek-a-boo/patty cake Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: INDICATES GUIDANCE GIVEN: Drowning prevention Emergency 911
 Sun safety Baby proofing Car seat/rear facing Introduce board books/mouthing Introduce cup Passive smoke
 Teething/tooth brushing Sleep/wake cycle Parent reads to child Refrain from jump seat/walker Begin using high chair
 Other

BEHAVIORAL HEALTH SCREEN: INDICATES OBSERVED BY CLINICIAN/PARENT REPORT Family Adjustment/parent responds positively to baby Encourage holding Self calming Wary of strangers Recognizes familiar people Distinguishes emotions by tone of voice Enjoys social play Other

COMPREHENSIVE PHYSICAL EXAM:

Skin/Hair/Nails		Lungs	
Eyes/Vision		Abdomen	
Ear		Genitourinary	
Mouth/Throat/Teeth		Extremities	
Nose/Head/Neck		Spine	
Heart		Neurological	

ASSESSMENT/PLAN/FOLLOW UP

	<input checked="" type="checkbox"/> INDICATES ORDERED <input type="checkbox"/>
	<input checked="" type="checkbox"/> INDICATES ORDERED <input type="checkbox"/> Pt. Needs immunization today <input type="checkbox"/> Delayed/Deferred <input type="checkbox"/> Parent refuses <input type="checkbox"/> Other reason <input type="checkbox"/> Hepatitis B <input type="checkbox"/> DTaP <input type="checkbox"/> Hib <input type="checkbox"/> IPV <input type="checkbox"/> PCV <input type="checkbox"/> Influenza <input type="checkbox"/> Rotavirus <input type="checkbox"/> Other
	<input checked="" type="checkbox"/> INDICATES REFERRED <input type="checkbox"/> CRS <input type="checkbox"/> WIC <input type="checkbox"/> ALTCS <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Audiology <input type="checkbox"/> Speech <input type="checkbox"/> AzEIP/ DDD <input type="checkbox"/> Developmental <input type="checkbox"/> Behavioral <input type="checkbox"/> Early Head Start <input type="checkbox"/> Specialty <input type="checkbox"/> Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note Yes No

Date	Last Name	First Name	AHCCCS ID #	DOB
				Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship
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NICU: <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS : <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS Pathway:	Birth Wt:	Allergies:	Temp:	Pulse:	Resp:
Risk indicators of hearing loss: <input type="checkbox"/> yes <input type="checkbox"/> no		Medications:		Wt: %	Length: %	Head circ: %	

PARENTAL CONCERNS/HISTORY:

VERBAL LEAD RISK ASSESSMENT: INDICATES GUIDANCE GIVEN: At risk yes no (if yes, a blood lead test is required)

ORAL SCREENING: INDICATES GUIDANCE GIVEN: Brushing teeth White spots on teeth

NUTRITIONAL SCREEN: INDICATES GUIDANCE GIVEN: Adequate intake Breast fed Formula: _____
 Soda/Juice Solids Supplements:

DEVELOPMENTAL SCREEN: Goes from sitting to all fours Peek-a-boo Uses words such as "mama/dada" Sits independently Repeats sounds/gestures for attention Explores environment Waves bye-bye Drinks from cup Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: INDICATES GUIDANCE GIVEN: Drowning prevention Emergency 911
 Sun Safety Baby proofing Car seat/rear facing Sleep/wake cycle Wary of strangers Introduce board books
 Soft texture finger foods/choking Redirection/positive parenting Exploration/learning Passive smoke Language/read to child Follow child's lead in play Parent communicates to child "what things are"(ball, cat etc) Other

BEHAVIORAL HEALTH SCREEN: INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: Family Adjustment/parent responds positively to child Encourage holding Self calming Growing Independence Shows preference for certain people/toys Cries when primary care giver leaves Other

COMPREHENSIVE PHYSICAL EXAM:

Skin/Hair/Nails		Lungs	
Eyes/Vision		Abdomen	
Ear		Genitourinary	
Mouth/Throat/Teeth		Extremities	
Nose/Head/Neck		Spine	
Heart		Neurological	

ASSESSMENT/PLAN/FOLLOW UP

INDICATES ORDERED Hgb/Hct (perform at 9 months) Other

INDICATES ORDERED Pt. Needs immunization today Delayed/Deferred Parent refuses Other reason Hepatitis B DTaP Hib IPV PCV Influenza Other

INDICATES REFERRED CRS WIC ALTCS PT OT Audiology Speech AzeIP/DDD Developmental Behavioral Early Head Start Specialty Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note Yes No

12 Months Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
Primary Care Provider		PCP ph. #	Health Plan	Accompanied by (name)	
				Relationship	

NICU: <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS : <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS Pathway:	Birth Wt:	Allergies:	Temp:	Pulse:	Resp:
Risk indicators of hearing loss: <input type="checkbox"/> yes <input type="checkbox"/> no		Medications:	Wt:	%	Length:	%	Head circ:
							%

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN: INDICATES GUIDANCE GIVEN: Daily tooth brushing First dental appointment White spots on teeth yes no

NUTRITIONAL SCREEN: INDICATES GUIDANCE GIVEN: Breast fed Formula: _____

Adequate intake Solids: _____

Supplements _____ Soda Juice

DEVELOPMENTAL SCREEN: INDICATES ACCOMPLISHMENTS: First steps "Mama" "dada" specific Uses single words

Scribbles Precise pincer grasp Follows simple one step requests Looks for hidden objects Extends arm/leg for

dressing Point to/label pictures Plays: hides object/pushes ball back and forth Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: INDICATES GUIDANCE GIVEN: Drowning prevention Emergency 911

Sun safety Passive smoke Car seat safety/20#'s AND 1 year = forward facing Weaning plan/milk intake

Discipline/praise Follow child's lead in play Ignore tantrums/give attention to positive behaviors Other

BEHAVIORAL HEALTH SCREEN: INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: Family adjustment/parent responds positively

to child Self calming Prefers primary care giver over all others Shy/anxious with strangers

COMPREHENSIVE PHYSICAL EXAM:

Skin/Hair/Nails	Lungs
Eyes/Vision	Abdomen
Ear	Genitourinary
Mouth/Throat/Teeth	Extremities
Nose/Head/Neck	Spine (scoliosis)
Heart	Neurological

ASSESSMENT/PLAN/FOLLOW UP:

INDICATES ORDERED Blood Lead Test (perform at 12 months) TB skin test (if at risk) Other

INDICATES ORDERED Pt. Needs immunization today Delayed/Deferred Parent refuses Other reason Had chicken pox Hep A HepB MMR Varicella DtaP Hib IPV PCV Influenza

INDICATES REFERRED CRS WIC ALTCS PT OT Audiology Speech AzEIP/ DDD Developmental Behavioral Early Head Start Dental Specialty Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note Yes No

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
Primary Care Provider		PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS : <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS Pathway:	Birth Wt:	Allergies:	Temp:	Pulse:	Resp:
Risk indicators of hearing loss: <input type="checkbox"/> yes <input type="checkbox"/> no	Medications:	Wt:	%	Length:	%	Head circ	%

PARENTAL CONCERNS/HISTORY:

VERBAL LEAD RISK ASSESSMENT: INDICATES GUIDANCE GIVEN: At risk yes no (if yes a blood lead test is required)

DENTAL SCREENING: INDICATES GUIDANCE GIVEN: Brushing daily 1st Dental appointment White spots on teeth

NUTRITIONAL SCREEN: INDICATES GUIDANCE GIVEN: Feeds self Breast fed/whole milk Nutritionally balanced diet Junk food Soda/Juice Over weight Activity Supplements _____
 Solids

DEVELOPMENTAL SCREEN: INDICATES ACCOMPLISHMENTS: Says 3-6 words Says No Wide range of emotions Repeats words from conversation Knows one color Understands simple commands Climbs stairs Walking Puts objects in container and takes object out of container Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: INDICATES GUIDANCE GIVEN: Drowning prevention Emergency 911 Sun safety Car seat safety/40#'s/4 years Gentle limit setting/redirection/safety Reading/parent asks child "what's that?"
 Manage growing independence/defiant behavior Follow child's lead in play Offer opportunity to scribble/explore Other

BEHAVIORAL HEALTH SCREEN: INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: Family adjustment/parent responds positively to child Encourage holding Self calming Frustration/hitting/biting/impulse control Communication/language Social interaction/eye contact/comforts others Begins to have definite preferences Other

UUCOMPREHENSIVE PHYSICAL EXAM:

Skin/Hair/Nails	Lungs
Eyes/Vision	Abdomen
Ear	Genitourinary
Mouth/Throat/Teeth	Extremities
Nose/Head/Neck	Spine
Heart	Neurological

ASSESSMENT/PLAN/FOLLOW UP

<input checked="" type="checkbox"/> INDICATES ORDERED <input type="checkbox"/> TB skin test (if at risk)
<input checked="" type="checkbox"/> INDICATES ORDERED <input type="checkbox"/> Pt. Needs immunization today <input type="checkbox"/> Delayed/Deferred <input type="checkbox"/> Parent refuses <input type="checkbox"/> Other reason <input type="checkbox"/> History of chicken pox <input type="checkbox"/> HepA <input type="checkbox"/> HepB <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> DTaP <input type="checkbox"/> Hib <input type="checkbox"/> IPV <input type="checkbox"/> PCV <input type="checkbox"/> Influenza <input type="checkbox"/> Other
<input checked="" type="checkbox"/> INDICATES REFERRED <input type="checkbox"/> CRS <input type="checkbox"/> WIC <input type="checkbox"/> ALTCS <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Audiology <input type="checkbox"/> Speech <input type="checkbox"/> AzEIP/DDD <input type="checkbox"/> Developmental <input type="checkbox"/> Behavioral <input type="checkbox"/> Dental <input type="checkbox"/> Early Head Start <input type="checkbox"/> Specialty <input type="checkbox"/> Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note Yes No

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
Primary Care Provider		PCP ph. #	Health Plan	Accompanied by (name)	
				Relationship	

NICU: <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS : <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS Pathway:	Allergies:				Temp:	Pulse:	Resp:
Risk indicators of hearing loss: <input type="checkbox"/> yes <input type="checkbox"/> no	Medications:	Birth Wt:	Wt:	%	Length:	%	Head circ:	%	

PARENTAL CONCERNS/HISTORY:

VERBAL LEAD RISK ASSESSMENT: INDICATES GUIDANCE GIVEN: At risk yes no

DENTAL SCREEN: INDICATES GUIDANCE GIVEN: Brushing daily 1st Dental appointment White spots on teeth

NUTRITIONAL SCREEN: INDICATES GUIDANCE GIVEN: Breast fed/whole milk Feeds self Nutritionally balanced diet
 Junk food Soda/Juice Over weight Activity Supplements _____
 Solids

DEVELOPMENTAL SCREEN: INDICATES ACCOMPLISHMENTS Uses a cup Walks Says 10-20 words Says "No" Name one picture/2 colors/
 Follows simple rules/bring me the book Knows animal sounds Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: INDICATES GUIDANCE GIVEN: Drowning prevention Emergency 911
 Discipline/limits Read to child Dental caries prevention Sibling interaction Nutrition/mealtimes Defiant behavior/offer child choices
 Never leave toddler alone Growing independence Encourage expression of wide range of emotions Other

BEHAVIORAL HEALTH SCREEN: INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: Family adjustment/parent responds positively to child
 Encourage holding Self calming Frustration/hitting/biting/impulse control Communication/language
 Demonstrates increasing independence Begins to show defiant behavior Other

COMPREHENSIVE PHYSICAL EXAM:

Skin/Hair/Nails		Lungs	
Eyes/Vision		Abdomen	
Ear		Genitourinary	
Mouth/Throat/Teeth		Extremities	
Nose/Head/Neck		Spine	
Heart		Neurological	

ASSESSMENT/PLAN/FOLLOW UP

	<input checked="" type="checkbox"/> INDICATES ORDERED <input type="checkbox"/> TB skin test (if at risk) <input type="checkbox"/> Other <input type="checkbox"/>
	<input checked="" type="checkbox"/> INDICATES ORDERED <input type="checkbox"/> Pt. Needs immunization today <input type="checkbox"/> Delayed/Deferred <input type="checkbox"/> Parent refuses <input type="checkbox"/> Other reason <input type="checkbox"/> History of chicken pox <input type="checkbox"/> HepA <input type="checkbox"/> HepB <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> DTaP <input type="checkbox"/> Hib <input type="checkbox"/> IPV <input type="checkbox"/> PCV <input type="checkbox"/> Influenza <input type="checkbox"/> Other
	<input checked="" type="checkbox"/> INDICATES REFERRED <input type="checkbox"/> CRS <input type="checkbox"/> WIC <input type="checkbox"/> ALTCS <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Audiology <input type="checkbox"/> Speech <input type="checkbox"/> AzEIP/DDD <input type="checkbox"/> Developmental <input type="checkbox"/> Behavioral <input type="checkbox"/> Dental <input type="checkbox"/> Early Head Start <input type="checkbox"/> Specialty <input type="checkbox"/> Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note Yes No

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship
NICU: <input type="checkbox"/> yes <input type="checkbox"/> no		PEDS : <input type="checkbox"/> yes <input type="checkbox"/> no		PEDS Pathway:
Allergies:			Temp:	Pulse:
Resp:			Birth Wt:	Wt:
Risk indicators of hearing loss: <input type="checkbox"/> yes <input type="checkbox"/> no			Medications:	%
			Ht:	%
			Head circ:	%

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN: INDICATES GUIDANCE GIVEN: Brushing/flossing (by parent) 1stDental appointment White spots on teeth

NUTRITIONAL SCREEN: INDICATES GUIDANCE GIVEN: Feeds self Nutritionally balanced diet Junk food Soda/Juice
 Over weight Activity Supplements

DEVELOPMENTAL SCREEN: INDICATES ACCOMPLISHMENTS: Kicks a ball stacks 5-6 blocks 20 word vocabulary Walks up stairs/runs well Communicates needs in 2-4 word sentences Names 6 body parts Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: INDICATES GUIDANCE GIVEN: Sleep practices Drowning prevention
 Emergency 911 Sun safety Nutrition/exercise Toilet training Discipline/redirection/praise read to child Car safety/booster seat/5 pt harness Learns 5-6 words every week Provide opportunities for success/choice: 2 items “juice or milk”/“red or blue shirt” Praise for effort/success Establish daily routine Encourage/support wide range of emotions
 Trike/bike safety Other

BEHAVIORAL HEALTH SCREEN: INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: Family adjustment/parent responds positively to child Encourage holding Self calming Frustration/hitting/biting/impulse control Communication/language Sense of humor Demonstrates increasing independence Plays alongside peers Other

COMPREHENSIVE PHYSICAL EXAM:

Skin/Hair/Nails		Lungs	
Eyes/Vision		Abdomen	
Ear		Genitourinary	
Mouth/Throat/Teeth		Extremities	
Nose/Head/Neck		Spine	
Heart		Neurological	

ASSESSMENT/PLAN/FOLLOW UP

	<input checked="" type="checkbox"/> INDICATES ORDERED <input type="checkbox"/> Blood Lead test (perform at 24 months) <input type="checkbox"/> TB skin test (if at risk) <input type="checkbox"/> Other
	<input checked="" type="checkbox"/> INDICATES ORDERED <input type="checkbox"/> Pt. Needs immunization today <input type="checkbox"/> Delayed/Deferred <input type="checkbox"/> Parent refuses <input type="checkbox"/> Other reason <input type="checkbox"/> Had chicken pox <input type="checkbox"/> HepA <input type="checkbox"/> HepB <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> DTaP <input type="checkbox"/> Hib <input type="checkbox"/> IPV <input type="checkbox"/> PCV <input type="checkbox"/> Influenza <input type="checkbox"/> Other
	<input checked="" type="checkbox"/> INDICATES REFERRED <input type="checkbox"/> CRS <input type="checkbox"/> WIC <input type="checkbox"/> ALTCS <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Audiology <input type="checkbox"/> ST <input type="checkbox"/> AzEIP/DDD <input type="checkbox"/> Developmental <input type="checkbox"/> Behavioral <input type="checkbox"/> Dental <input type="checkbox"/> Early Head Start <input type="checkbox"/> Specialty <input type="checkbox"/> Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note Yes No

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
Primary Care Provider		PCP ph. #	Health Plan	Accompanied by (name)	
Relationship					
NICU: <input type="checkbox"/> yes <input type="checkbox"/> no PEDS: <input type="checkbox"/> yes <input type="checkbox"/> no		PEDS Pathway: OD OS OU		Allergies:	
Rt. <input type="checkbox"/> pass <input type="checkbox"/> refer Lt. <input type="checkbox"/> pass <input type="checkbox"/> refer		Corrected <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> Unable to perform		Temp:	Pulse:
Speech: age appropriate <input type="checkbox"/> yes <input type="checkbox"/> no		Medications:		Resp:	B/P
Wt:		%	BMI:	%	Ht:
				%	%

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN: INDICATES GUIDANCE GIVEN: Brushing/flossing (by parent) daily Dental appointment White spots on teeth

NUTRITIONAL SCREEN: INDICATES GUIDANCE GIVEN: Nutritionally balanced diet Junk food Soda/Juice
 Over weight Activity Supplements

DEVELOPMENTAL SCREEN: INDICATES ACCOMPLISHMENTS Uses imaginary characters Matches colors and shapes Counts to 5
 Names self and others Knows gender Begins to play: games with simple rules/interactive games Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: INDICATES GUIDANCE GIVEN: Sport helmet use Drowning prevention
 Emergency 911 Sun safety Nutrition/exercise Toilet training Discipline/redirect Reading/preschool Car Safety/booster seat/5 pt harness
 Provide opportunities for pretend & fantasy/problem solving & choices/drawing & scribbling
 Establish routine for: bed/meals/toileting etc. Allow child to play independently/be available if child seeks you out Other

BEHAVIORAL HEALTH SCREEN: INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: Family adjustment/parent responds positively to child
 Self calming "Monster" fear Frustration/hitting/biting/impulse control Communication/language Pediatric Symptom Checklist
 Has words for feelings Separates easily from parent Objects to major change in routine Shows interest in other children
 Feels competent Kind to animals Other

COMPREHENSIVE PHYSICAL EXAM:

Skin/Hair/Nails		Lungs	
Eyes/Vision		Abdomen	
Ear		Genitourinary	
Mouth/Throat/Teeth		Extremities	
Nose/Head/Neck		Spine	
Heart		Neurological	

ASSESSMENT/PLAN/FOLLOW UP

	<input checked="" type="checkbox"/> INDICATES ORDERED <input type="checkbox"/> Hgb/Hct <input type="checkbox"/> Urinalysis <input type="checkbox"/> TB skin test (if at risk) <input type="checkbox"/> Blood Lead Test (perform at 36 – 72 months if not already done) <input type="checkbox"/> Other
	<input checked="" type="checkbox"/> INDICATES ORDERED <input type="checkbox"/> Pt. Needs immunization today <input type="checkbox"/> Delayed/Deferred <input type="checkbox"/> Parent Refuses <input type="checkbox"/> Other reason <input type="checkbox"/> Had chicken pox <input type="checkbox"/> HepA <input type="checkbox"/> HepB <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> DTaP <input type="checkbox"/> Hib <input type="checkbox"/> IPV <input type="checkbox"/> PCV <input type="checkbox"/> Influenza <input type="checkbox"/> Other
	<input checked="" type="checkbox"/> INDICATES REFERRED <input type="checkbox"/> CRS <input type="checkbox"/> WIC <input type="checkbox"/> DDD <input type="checkbox"/> ALTCS <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Audiology <input type="checkbox"/> ST <input type="checkbox"/> Developmental <input type="checkbox"/> Behavioral <input type="checkbox"/> Dental <input type="checkbox"/> Head Start <input type="checkbox"/> Specialty <input type="checkbox"/> Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note Yes No

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
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Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship
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NICU: <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS Pathway:	Allergies:	Temp:	Pulse:	Resp:	B/P
			OD OS OU				
Rt. <input type="checkbox"/> pass <input type="checkbox"/> refer Lt. <input type="checkbox"/> pass <input type="checkbox"/> refer <input type="checkbox"/> Unable to perform			Corrected <input type="checkbox"/> yes <input type="checkbox"/> no	Wt: %	BMI: %	Ht: %	
Speech: age appropriate <input type="checkbox"/> yes <input type="checkbox"/> no			Medications:				

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN: INDICATES GUIDANCE GIVEN: Brushing/flossing (by parent) daily Dental appointment White spots on teeth

NUTRITIONAL SCREEN: INDICATES GUIDANCE GIVEN: Nutritionally balanced diet Junk food Soda/Juice
 Over weight Activity Supplements

DEVELOPMENTAL SCREEN: INDICATES ACCOMPLISHMENTS: Sings a song Draws a person with 3 parts Gives first/last name
 Names 6-8 colors/3 shapes Counts 1-7 objects out loud (not always in order) Names self and others Shows interest in other children
 Plays interactive with simple rules Asks/answers who, what, where, why Follows 2 unrelated directions
 Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: INDICATES GUIDANCE GIVEN: Sport helmet use Drowning prevention
 Emergency 911 Sun safety Safe at Home Nutrition/exercise Toilet training Discipline/redirect
 Reading/preschool Car Safety/booster seat/5 pt harness Provide opportunities for pretend & fantasy/problem solving & choices/drawing & scribbling
 Establish routine for bed/meals/toileting etc. Allow child to play independently/be available if child seeks you out Other

BEHAVIORAL HEALTH SCREEN: INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: Family adjustment/parent responds positively to child
 Self calming Communication/language Pediatric Symptom Checklist Separates easily from parent Feels competent
 Kind to animals Objects to major change in routine Has words for feelings Other

COMPREHENSIVE PHYSICAL EXAM:

Skin/Hair/Nails		Lungs	
Eyes/Vision		Abdomen	
Ear		Genitourinary	
Mouth/Throat/Teeth		Extremities	
Nose/Head/Neck		Spine	
Heart		Neurological	

ASSESSMENT/PLAN/FOLLOW UP

INDICATES ORDERED Hgb/Hct Urinalysis TB skin test (if at risk) Other
 Blood Lead Test (perform at 36 – 72 months if not already done)

INDICATES ORDERED Pt. Needs immunization today Delayed/Deferred Parent refuses Other reason
 Had chicken pox HepA HepB MMR Varicella DTaP Hib IPV Influenza
 PCV Other

INDICATES REFERRED CRS WIC DDD ALTCS PT OT Audiology Speech
 Developmental Behavioral Dental Head Start Specialty Other

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship
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NICU: <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS Pathway:				Allergies:	Temp:	Pulse:	Resp:	B/P	
			OD	OS	OU						
			Corrected <input type="checkbox"/> yes <input type="checkbox"/> no			Wt:	%	BM I:	%	Ht:	%
Rt. <input type="checkbox"/> pass <input type="checkbox"/> refer Lt. <input type="checkbox"/> pass <input type="checkbox"/> refer			<input type="checkbox"/> Unable to perform								
Speech: age appropriate <input type="checkbox"/> yes <input type="checkbox"/> no			Medications:								

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN: INDICATES GUIDANCE GIVEN: Brushing 2x /Flossing daily Dental appointment White spots on teeth

NUTRITIONAL SCREEN: INDICATES GUIDANCE GIVEN: Nutritionally balanced diet Junk food Soda/Juice
 Over weight Activity Supplements

DEVELOPMENTAL SCREEN: INDICATES ACCOMPLISHMENTS Recognizes most letters/shapes/numbers to 10 Recognize/identify some letters and phonic sounds Sorts and counts up to 5 objects Holds pencil Cuts with scissors Cooperates more in group setting Runs/skips/jumps Begins to agree with rules Can button and zip clothing independently Goes to bathroom independently Likes to sing/dance/act Knows address Plays board games Dictates story to adults Listens to authority figure and follows instructions Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: INDICATES GUIDANCE GIVEN: Sport/bike helmet use Drowning prevention Emergency 911 Sun safety Safe at home Nutrition/exercise Street safety Discipline/redirect Reading School readiness Set only 3-5 rules for your child Car seat <40 lbs/belt positioning booster seat <4'9"/air bags Other

BEHAVIORAL HEALTH SCREEN: INDICATES OBSERVED BY CLINICIAN/PARENT REPORT Family adjustment/parent responds positively to child Self calming Communication/language Pediatric Symptom Checklist Shows empathy for others Wants to please & be with friends Positive about self & abilities Tells stories of convenience(lying) Other

COMPREHENSIVE PHYSICAL EXAM:

Skin/Hair/Nails		Lungs	
Eyes/Vision		Abdomen	
Ear		Genitourinary	
Mouth/Throat/Teeth		Extremities	
Nose/Head/Neck		Spine	
Heart		Neurological	

ASSESSMENT/PLAN/FOLLOW UP

	<input checked="" type="checkbox"/> INDICATES ORDERED <input type="checkbox"/> Hgb/Hct <input type="checkbox"/> Urinalysis (to be completed at 5 years) <input type="checkbox"/> TB skin test (if at risk) <input type="checkbox"/> Other <input type="checkbox"/> Blood Lead Test (perform at 36 – 72 months if not already done)
	<input checked="" type="checkbox"/> INDICATES ORDERED <input type="checkbox"/> Pt. Needs immunization today <input type="checkbox"/> Delayed/Deferred <input type="checkbox"/> Parent refuses <input type="checkbox"/> Other reason <input type="checkbox"/> Had chicken pox <input type="checkbox"/> HepA <input type="checkbox"/> HepB <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> DTaP <input type="checkbox"/> IPV <input type="checkbox"/> Influenza <input type="checkbox"/> Other
	<input checked="" type="checkbox"/> INDICATES REFERRED <input type="checkbox"/> CRS <input type="checkbox"/> WIC <input type="checkbox"/> DDD <input type="checkbox"/> ALTCS <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Audiology <input type="checkbox"/> ST <input type="checkbox"/> Developmental <input type="checkbox"/> Behavioral <input type="checkbox"/> Dental <input type="checkbox"/> Specialty

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note Yes No

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
Primary Care Provider		PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS Pathway:	OD	OS	OU	Allergies:	Temp:	Pulse:	Resp:	B/P	
<input type="checkbox"/> WNL <input type="checkbox"/> Abnormal			<input type="checkbox"/> Corrected <input type="checkbox"/> yes <input type="checkbox"/> no			Wt:	%	BMI:	%	Ht:	%
Speech: age appropriate <input type="checkbox"/> yes <input type="checkbox"/> no			Medications:								

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN: INDICATES GUIDANCE GIVEN: Brushing 2x /Flossing daily Dental appointment White spots on teeth

NUTRITIONAL SCREEN: INDICATES GUIDANCE GIVEN: Nutritionally balanced diet Junk food Soda/Juice
 Over weight Activity Supplements

DEVELOPMENTAL SCREEN: INDICATES ACCOMPLISHMENTS Language is expressive and understandable School attendance
 Reading at grade level Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: INDICATES GUIDANCE GIVEN: Sport/bike helmet use Drowning prevention
 Emergency 911 Sun safety Safe at Home Nutrition/exercise Street safety Discipline/redirect Reading
 School readiness Belt positioning booster seat <4'9"/air bags
 Provide opportunities for social interaction/invite friends over to play board games/dress up etc. Other

BEHAVIORAL HEALTH SCREEN: INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: Family adjustment/parent responds positively to child
 Frustration/impulse control Communication/language Has friends Plays well with others/by self Is liked by other children
 Feels capable Expresses full range of emotions Pediatric Symptom Checklist Other

COMPREHENSIVE PHYSICAL EXAM:

Skin/Hair/Nails		Lungs	
Eyes/Vision		Abdomen	
Ear		Genitourinary	
Mouth/Throat/Teeth		Extremities	
Nose/Head/Neck		Spine	
Heart		Neurological	

ASSESSMENT/PLAN/FOLLOW UP

	<input checked="" type="checkbox"/> INDICATES ORDERED <input type="checkbox"/> Hgb/Hct <input type="checkbox"/> Urinalysis <input type="checkbox"/> TB skin test (if at risk) <input type="checkbox"/> Other <input type="checkbox"/> Blood Lead Test (perform at 36 – 72 months if not already done)
	<input checked="" type="checkbox"/> INDICATES ORDERED <input type="checkbox"/> Pt. Needs immunization today <input type="checkbox"/> Delayed/Deferred <input type="checkbox"/> Parent refuses <input type="checkbox"/> Other reason <input type="checkbox"/> Had chicken pox <input type="checkbox"/> HepA <input type="checkbox"/> HepB <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> DTaP <input type="checkbox"/> IPV <input type="checkbox"/> Influenza <input type="checkbox"/> Other
	<input checked="" type="checkbox"/> INDICATES REFERRED <input type="checkbox"/> CRS <input type="checkbox"/> WIC <input type="checkbox"/> DDD <input type="checkbox"/> ALTCS <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Audiology <input type="checkbox"/> ST <input type="checkbox"/> Developmental <input type="checkbox"/> Behavioral <input type="checkbox"/> Dental <input type="checkbox"/> Specialty <input type="checkbox"/> Other

Date/Time Clinician name (print)

Clinician Signature

See Additional Supervisory note Yes No

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship	

NICU: <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS <input type="checkbox"/> yes <input type="checkbox"/> no	PEDS Pathway:	OD	OS	OU	Allergies:	Temp:	Pulse:	Resp:	B/P	
<input type="checkbox"/> WNL			<input type="checkbox"/> Abnormal			Wt:			%		
<input type="checkbox"/> Corrected			<input type="checkbox"/> yes <input type="checkbox"/> no			BMI:			%		
Speech: age appropriate			<input type="checkbox"/> yes <input type="checkbox"/> no			Ht:			%		
Medications:											

PARENTAL/PATIENT CONCERNS/HISTORY:

DENTAL SCREEN: INDICATES GUIDANCE GIVEN: Brushing 2x /Flossing daily Dental appointment White spots on teeth

NUTRITIONAL SCREEN: INDICATES GUIDANCE GIVEN: Nutritionally balanced diet Junk food Soda/Juice
 Over weight Activity Supplements

DEVELOPMENTAL SCREEN: INDICATES ACCOMPLISHMENTS: School attendance Reading at grade level Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: INDICATES GUIDANCE GIVEN: Sport/bike helmet use Drowning prevention
 Emergency 911 Sun safety Safe at Home Nutrition/exercise Street safety Discipline Reading School readiness
 Belt positioning booster seat <4'9"/air bags Bullying Other

BEHAVIORAL HEALTH SCREEN: INDICATES OBSERVED BY CLINICIAN/PARENT REPORT Family adjustment/parent responds positively to child
 Frustration /impulse control Communication/language Comfortable body image Pediatric Symptom Checklist
 Other

COMPREHENSIVE PHYSICAL EXAM:

Skin/Hair/Nails		Lungs	
Eyes/Vision		Abdomen	
Ear		Genitourinary	
Mouth/Throat/Teeth		Extremities	
Nose/Head/Neck		Spine	
Heart		Neurological	

ASSESSMENT/PLAN/FOLLOW UP

	<input checked="" type="checkbox"/> INDICATES ORDERED <input type="checkbox"/> Hgb/Hct <input type="checkbox"/> Urinalysis <input type="checkbox"/> TB skin test (if at risk) <input type="checkbox"/> Other
	<input checked="" type="checkbox"/> INDICATES ORDERED <input type="checkbox"/> Pt. Needs immunization today <input type="checkbox"/> Delayed <input type="checkbox"/> Deferred <input type="checkbox"/> Hep A <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> Td <input type="checkbox"/> Influenza <input type="checkbox"/> Hep B <input type="checkbox"/> IPV <input type="checkbox"/> Other
	<input checked="" type="checkbox"/> INDICATES REFERRED <input type="checkbox"/> CRS <input type="checkbox"/> WIC <input type="checkbox"/> DDD <input type="checkbox"/> ALTCS <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Audiology <input type="checkbox"/> ST <input type="checkbox"/> Developmental <input type="checkbox"/> Behavioral <input type="checkbox"/> Dental <input type="checkbox"/> Specialty

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note Yes No

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
Primary Care Provider		PCP ph. #	Health Plan	Accompanied by (name)	
				Relationship	

			Menses		Allergies:		B/P:	Temp:	Pulse:	Resp:	
OD	OS	OU	<input type="checkbox"/> Unable to perform	<input type="checkbox"/> WNL	<input type="checkbox"/> Abnl	<input type="checkbox"/> yes <input type="checkbox"/> no					
Corrected			<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> Unable to perform		Menarche	LMP	Wt:	%	BMI:	%
						Ht:	%				

Medications:

PARENTAL/PATIENT CONCERNS:

HEALTH RISK ASSESSMENT: Early Adolescent GAPS (begin at 10 years) Other

DENTAL SCREEN: INDICATES GUIDANCE GIVEN: Brushing 2x /Flossing daily Dental appointment White spots on teeth

NUTRITIONAL SCREEN: INDICATES GUIDANCE GIVEN: Nutritionally balanced diet Junk food Soda/Juice
 Over weight Activity Supplements

DEVELOPMENTAL SCREEN: INDICATES ACCOMPLISHMENTS: Early adolescence: School attendance Reading at grade level
 Dating Sexuality/orientation Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: INDICATES GUIDANCE GIVEN: Sports/injury prevention Drowning/sun safety
 Nutrition/exercise Safe at Home Seat belt/air bags Sex education/STI Peer refusal skills Violence prevention/gun safety
 Depression/anxiety Tobacco/alcohol/drugs/Rx drugs/inhalants Education goals/activities Social interaction
 Risks of tattoos/ piercing After school activities/supervision Bullying Self control Other

Behavioral Health Screen: INDICATES OBSERVED BY CLINICIAN/PARENT REPORT Comfortable body image Other

COMPREHENSIVE PHYSICAL EXAM:

Skin/Hair/Nails		Lungs	
Eyes/Vision		Abdomen	
Ear		Genitourinary Tanner stage _____	
Mouth/Throat/Teeth		Extremities	
Nose/Head/Neck		Spine	
Heart		Neurological	

ASSESSMENT/PLAN/FOLLOW UP

	<input checked="" type="checkbox"/> INDICATES ORDERED <input type="checkbox"/> Hgb/Hct <input type="checkbox"/> Urinalysis <input type="checkbox"/> Lipid Profile <input type="checkbox"/> TB skin test (if at risk) <input type="checkbox"/> Other
	<input checked="" type="checkbox"/> INDICATES ORDERED <input type="checkbox"/> Pt. Needs immunization today <input type="checkbox"/> Delayed <input type="checkbox"/> Deferred <input type="checkbox"/> Tdap (11 - 12years only) <input type="checkbox"/> Meningococcal (11 – 12 years only) <input type="checkbox"/> HPV (11 – 12 years) <input type="checkbox"/> Hepatitis A <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Td <input type="checkbox"/> Influenza <input type="checkbox"/> IPV <input type="checkbox"/> Other
	<input checked="" type="checkbox"/> INDICATES REFERRED <input type="checkbox"/> CRS <input type="checkbox"/> WIC <input type="checkbox"/> DDD <input type="checkbox"/> ALTCS <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Audiology <input type="checkbox"/> Speech <input type="checkbox"/> Developmental <input type="checkbox"/> Behavioral <input type="checkbox"/> Dental <input type="checkbox"/> Specialty

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note Yes No

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
Primary Care Provider		PCP ph. #	Health Plan	Accompanied by (name)	Relationship

			Menses		Allergies:			B/P	Temp:	Pulse:	Resp:
OD	OS	OU	<input type="checkbox"/> Unable to perform	<input type="checkbox"/> WNL	<input type="checkbox"/> Abnl	<input type="checkbox"/> yes <input type="checkbox"/> no					
Corrected <input type="checkbox"/> yes <input type="checkbox"/> no			<input type="checkbox"/> Unable to perform	Menarche	LMP	Wt:	%	BMI:	%	Ht:	%
Medications:											

Parent/Patient Concerns/History:

HEALTH RISK ASSESSMENT: HEADDSS GAPS Other

DENTAL SCREENING: INDICATES GUIDANCE GIVEN: Brushing 2x /Flossing daily Dental appointment White spots on teeth

NUTRITIONAL SCREEN: INDICATES GUIDANCE GIVEN: Nutritionally balanced diet Junk food Soda/Juice
 Over weight Activity Supplements

DEVELOPMENTAL SCREEN: INDICATES ACCOMPLISHMENTS: Middle Adolescence: School attendance Reading at grade level
 Dating Sexuality/orientation Risk taking (Learning to drive 15 to 17 years) Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: INDICATES GUIDANCE GIVEN: Sports/injury prevention Drowning/sun safety
 Nutrition/exercise Safe at Home Seat belt/air bags Sex education/STD/resources Self control Peer refusal skills
 Bullying Violence prevention/gun safety Depression/anxiety Tobacco/alcohol/drugs/Rx drugs/inhalants Education goals/activities
 Social interaction Sexual orientation/dating Risks of tattoos/ piercing Availability of family planning services
 After school activities/supervision Other

BEHAVIORAL HEALTH SCREEN: INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: Comfortable body image Other

COMPREHENSIVE PHYSICAL EXAM:

Skin/Hair/Nails		Lungs	
Eyes/Vision		Abdomen	
Ear		Genitourinary Tanner stage _____	
Mouth/Throat/Teeth		Extremities	
Nose/Head/Neck		Spine	
Heart		Neurological	

ASSESSMENT/PLAN & FOLLOW UP

	<input checked="" type="checkbox"/> INDICATES ORDERED <input type="checkbox"/> Hgb/Hct <input type="checkbox"/> U/A (preferred at 16 yrs) <input type="checkbox"/> Lipid Profile <input type="checkbox"/> TB skin test (if at risk) <input type="checkbox"/> Other
	<input checked="" type="checkbox"/> INDICATES ORDERED <input type="checkbox"/> Pt. Needs immunization today <input type="checkbox"/> Delayed <input type="checkbox"/> Deferred <input type="checkbox"/> Hepatitis A <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Tdap <input type="checkbox"/> Influenza <input type="checkbox"/> Meningococcal <input type="checkbox"/> HPV <input type="checkbox"/> IPV <input type="checkbox"/> Td <input type="checkbox"/> Other
	<input checked="" type="checkbox"/> INDICATES REFERRED <input type="checkbox"/> CRS <input type="checkbox"/> WIC <input type="checkbox"/> DDD <input type="checkbox"/> ALTCs <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Audiology <input type="checkbox"/> Speech <input type="checkbox"/> Developmental <input type="checkbox"/> Behavioral <input type="checkbox"/> Dental <input type="checkbox"/> Specialty

Date/Time Clinician name (print)

Clinician Signature

See Additional Supervisory note Yes No

Date	Last Name	First Name	AHCCCS ID #	DOB
				Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship
-----------------------	-----------	-------------	-----------------------	--------------

					Menses	Allergies:			B/P	Temp:	Pulse:	Resp:	
OD	OS	OU	<input type="checkbox"/> Unable to perform	<input type="checkbox"/> WNL	<input type="checkbox"/> Abnl	<input type="checkbox"/> yes <input type="checkbox"/> no							
Corrected <input type="checkbox"/> yes <input type="checkbox"/> no			<input type="checkbox"/> Unable to perform		Menarche	LMP	Wt:	%	BMI:	%	Ht:	%	

Medications:

Patient Concerns/History:

HEALTH RISK ASSESSMENT: INDICATES ASSESSMENT USED: HEADDSS GAPS Other

DENTAL SCREENING: INDICATES GUIDANCE GIVEN: Brushing 2x /Flossing daily Dental appointment White spots on teeth

NUTRITIONAL SCREEN: INDICATES GUIDANCE GIVEN: Nutritionally balanced diet Junk food Soda/Juice
 Over weight Activity Supplements

DEVELOPMENTAL SCREEN: INDICATES ACCOMPLISHMENTS: Late Adolescence: Abstract thinking School attendance
 Sexuality/orientation Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: INDICATES GUIDANCE GIVEN: Sports/injury prevention Athletic activities
 Drowning/sun safety Nutrition/exercise Safe at Home Seat belt/air bags Sex education/STD/resources Self control
 Peer refusal skills Violence prevention/gun safety Depression/anxiety Tobacco/alcohol/drugs/Rx drugs/inhalants
 Education goals/activities Social interaction/dating Parenting advice (as appropriate) Future oriented Risks of tattoos/
 piercing Availability of family planning services Job/career planning Other

BEHAVIORAL HEALTH SCREEN: INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: Philosophical/idealistic Comfortable body
 image Building intimate, complex relationships Other

COMPREHENSIVE PHYSICAL EXAM:

Skin/Hair/Nails		Lungs	
Eyes/Vision		Abdomen	
Ear		Genitourinary Tanner stage	
Mouth/Throat/Teeth		Extremities	
Nose/Head/Neck		Spine	
Heart		Neurological	

ASSESSMENT/PLAN/FOLLOW UP

INDICATES ORDERED Hgb/Hct Urinalysis Lipid Profile TB skin test (if at risk) Other

INDICATES ORDERED Pt. Needs immunization today Delayed Deferred Hepatitis A MMR
 Varicella Hepatitis B Tdap Influenza Meningococcal HPV IPV Td Other

INDICATES REFERRED CRS WIC DDD ALTCS PT OT Audiology Speech
 Developmental Behavioral Dental OB/Gyn Specialty

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note Yes No

APPENDIX H:

MAP AND NAMES/TELEPHONE OF RBHAS

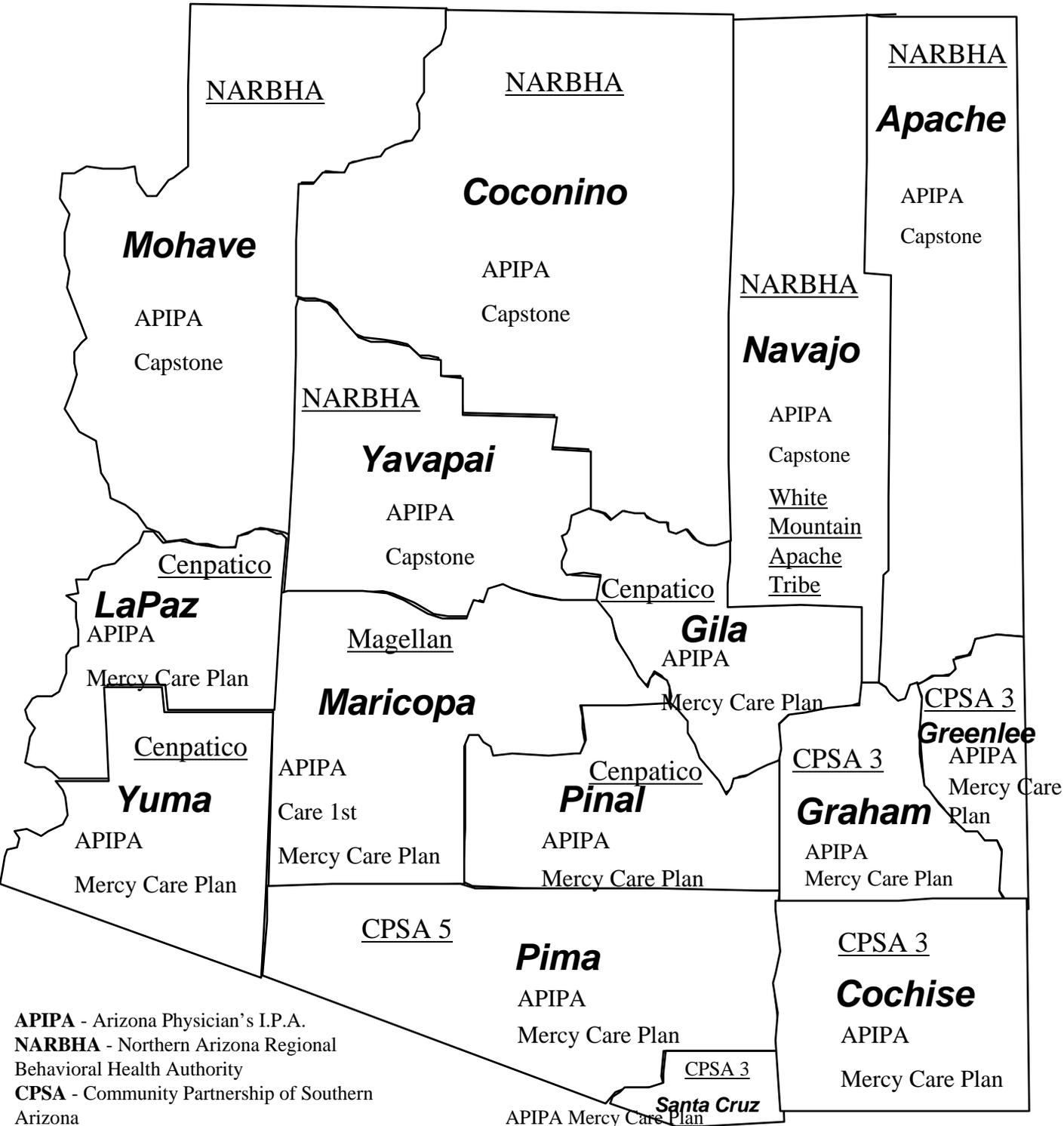
AND

RBHA REFERRAL FORM



AHCCCS Behavioral Health Service Guide Exhibit C

ALTCS DES/DD Map with Contracted Health Plans and RBHAs by County





AHCCCS BEHAVIORAL HEALTH SERVICES GUIDE

**Regional Behavioral Health Authorities
(RBHAs)**

NAME	COUNTIES OF OPERATION	MEMBER SERVICES NUMBER
Magellan	Maricopa	800-564-5465 After 5 p.m., callers can choose prompt for crisis line (staffed 24 hours) or call 800-631-1314 directly
Community Partnership of Southern Arizona (CPSA)	Pima, Santa Cruz, Cochise, Graham, Greenlee	800-771-9889 After 11 p.m. calls roll over to SAMHC (staffed 24 hours)
Northern Arizona Regional Behavioral Health Authority (NARBHA)	Coconino, Mohave, Navajo, Apache, Yavapai	928-774-7128 800-640-2123 After 5 p.m., calls roll over to an answering service. Crisis calls are directed to crisis providers.
Cenpatico	Pinal, Gila, Yuma, La Paz	Member Services 866-495-6738 Pinal County Gila County Yuma County La Paz County

Tribal Regional Behavioral Health Authorities and Contractors

NAME	MEMBER SERVICES NUMBER	WEB SITE ADDRESS
Pascua Yaqui Regional Tribal Behavioral Health Authority	520-879-6060	http://www.pascuayaqui-nsn.gov/community/programs/health/behavioral/index.shtml
Gila River Tribal Regional Behavioral Health Authority	602-528-7100	http://www.gilariverrbha.org/index/htm
Navajo Nation Behavioral Health Contractor	928-871-6877	http://www.navajo.org/
White Mountain Apache Tribe	928-338-4811	http://www.wmabhs.org

**PM FORM 3.3.1
ADHS/DBHS REFERRAL FOR BEHAVIORAL HEALTH SERVICES**

I. Information on Person Making Referral

Today's Date and Time _____

Name and Title _____

Affiliated Agency _____ Phone _____ Fax _____

Type of Service Requested: ___ One Time Consultation ___ Ongoing Behavioral Health Services

II. Information on Person Being Referred for Services

Name _____ Date of Birth _____ SS# _____ Gender F M

Address _____ Primary Language _____

City _____ State _____ Zip _____ Home Phone _____ Cell Phone _____

Current location (if not above address) _____

Parent/Legal Guardian (if applicable) _____ Phone _____

Identify individual(s) that the member, parent or guardian may wish to be invited to initial appointment with person
(include phone) _____

Person/Parent/Guardian is aware of referral: No Yes Cultural and language considerations No Yes

Is an interpreter needed , No Yes If yes, specify language/need _____

Special Needs:

Mobility Assistance No Yes, identify assistance needed _____

Visual Impairment Assistance No Yes, identify assistance needed _____

Hearing Impairment Assistance No Yes, identify assistance needed _____

Developmental or Cognitive Impairment No Yes, identify assistance needed _____

Payment Source: AHCCCS ID # _____ Self pay Private insurance Health Plan Medicare Other

PCP _____ Phone _____ Fax _____

Reason for Referral _____

III. Unable to contact person being referred

If the person is taking medications to treat a behavioral health condition, does she/he have an adequate supply for the next 30 days? Yes No, if no, when will she/he exhaust the current supply of medications _____

Number of outreach attempts _____

Type of Outreach and Engagement conducted (Check all that apply)

___ Phone Call Number of calls _____ ___ Face to face visit attempt Number of attempts _____

If unsuccessful, state reason why (check all that apply)

___ No answer to phone call(s) ___ Person being referred already enrolled in behavioral health services

___ Telephone disconnected ___ Person being referred refuses behavioral health services ___ Message(s) left with no response

___ Referral source notified of unsuccessful contact; if this box checked, list alternate contact information obtained:

IF UNABLE TO CONTACT-STOP HERE

IV. Information to Be Completed by network provider

Last revision: 05/08/2009

Effective date: 07/01/2009

Date / Time Received _____

If applicable, name and contact information of the provider that will assume primary responsibility for the person's behavioral health care: _____

Type of Appointment Immediate Urgent Routine

Available Intake Appointment Offered, specify date, time, place _____

Action Taken

Scheduled Intake Appointment, specify date, time, place _____

Not Referred for Appointment, specify why _____

Other Disposition, explain _____

V. Outcome (within 30 days)

Intake appointment kept ___Yes ___No

If no, why? Check all that apply:

___ Rescheduled by provider ___ Rescheduled by person being referred ___ Cancelled without rescheduling by person being referred ___ Person being referred was a "No show"

If no show, number of outreach and engagement efforts _____

Was the Assessment done on same day as Intake? Yes No

If no, date assessment scheduled for: _____

*****Please return form to referral source with "Action Taken" Section completed.*****

APPENDIX I:
CULTURALLY COMPETENT PATIENT CARE:
A GUIDE FOR PROVIDERS AND THEIR STAFF

CULTURALLY COMPETENT PATIENT CARE

A Guide for Providers and Their Staff

Institute for
Health Professions Education

Georgia G. Hall, Ph.D., MPH

OCTOBER 2001

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AHCCCS, Office of Managed Care

Arizona Providers, IPA, Inc.

CIGNA Community Choice

Cochise Health Systems

Health Choice Arizona

Institute for Health Professions Education

Lifemark Corporation Health Plan

Mercy Care Health Plan

Phoenix Health Plan

Pinal County Long Term Care

University Family Care

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David Brooks

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Section Four - Effective Patient Communication and Education Strategies

Section Five - Resources

SECTION ONE

INTRODUCTION

This guide is intended to help Providers and their staff meet the challenge of caring for an increasingly diverse patient population, whose culture - which includes language, lifestyle, values, beliefs and attitudes may, differ from those of the dominant society.

Since these and other elements of culture influence the experience of illness, access to care, and the process of getting well, Providers and their staff are compelled to learn about them and incorporate that knowledge into the patient care plan.

Cultural competence can be defined as a combination of knowledge, clinical skills and behaviors that lead to positive outcomes of patient care with ethnically and culturally diverse populations.

Central to cultural competency is the provision of services, education and information in appropriate languages and at appropriate comprehension and literacy levels.

Benefits of a culturally competent approach to care:

- Devise more appropriate plans of care
- Improve quality of patient care and outcomes
- Reduce patient non-compliance
- Improve patient satisfaction
- Provide enhanced individual and family care
- Gain sensitivity to patient needs
- Work more effectively with diverse patient populations
- Adhere to federal and state requirements

SECTION TWO

HEALTH BELIEFS, ATTITUDES, AND BEHAVIORS: IMPLICATIONS FOR CLINICAL CARE

Culturally competent healthcare

An understanding of value systems and their influence on health is essential to providing culturally competent healthcare. Every culture has a value system that dictates behavior directly or indirectly by setting and encouraging specific norms. Health beliefs and practices, in particular, reflect that value system.

Providing care for patients from diverse backgrounds requires understanding one's own values as well as the values of other groups. There is a natural tendency for people to be culture bound, that is, to assume that their values, customs, attitudes and behaviors are always appropriate and right.

The following list, comparing dominant Anglo–American values with those of more traditional cultures demonstrates their differing views.

<u>Anglo-American</u>	<u>More traditional cultures</u>
Personal control over environment	Fate
Change	Tradition
Time dominates	Human interaction dominates
Human equality	Hierarchy/rank/status
Individualism/privacy	Group welfare
Self-help	Birthright inheritance
Competition	Cooperation
Future Orientation	Past orientation
Action/goal/work Orientation/informality	“Being” orientation
Directness/openness/honesty	Formality
Practicality/efficiency	Idealism/Spiritualism

Source:
Cross-Cultural Counseling: A guide for Nutrition and Health Counselors, U.S. Department of Agriculture/US Department of Health and Human Services, Nutrition Education Committee for Maternal and Child Nutrition Publications, 1986.

General beliefs

- Beliefs about the cause, prevention, and treatment of illness vary among cultures. These beliefs dictate the practices used to maintain health. Health practices can be classified as folk, spiritual or psychic healing practices, and conventional medical practices. Patients may follow a specific process in seeking health care. Cultural healers may be used in addition to conventional medical care.

Understanding your values and beliefs

- Cross-cultural healthcare requires Providers and their staff to care for patients without making judgments about the superiority of one set of values over the other.
- Providers are not only influenced by the cultural values they were raised with, but also by the culture of medicine which has its own language and values. The complexity of the health care system today is time oriented, hierarchical and founded on disease management and the preservation of life at any cost. Realizing these values as part of the current medical culture will be useful when dealing with patients with different values.

Knowing your patient

- The difference between a Provider who is culturally competent and one who is culturally aware is in the service that person provides. A culturally competent Provider is aware of the cultural differences and even more aware of the individual and his or her personal needs.

Appreciate the heterogeneity that exists within cultural groups

- As studies about cultural and ethnic groups demonstrate, there are distinctive characteristics that contribute to their uniqueness. Knowledge about these unique characteristics is important to the development of culturally relevant programs.
- Since significant variability may exist between and among individuals from the same cultural and ethnic group, over-generalization is a danger. Such variability can be due to: age, level of education, family, rural/urban residence, religiosity, level of adherence to traditional customs, and for immigrant patients, degree of assimilation and acculturation.

The role of economics

- The culture of poverty is as important as a person's ethnicity, social status and cultural background. Economic status may influence the patient's ability to acquire medical supplies or other resources (such as running water, electricity, adequate space, healthful or specific diet, etc.) needed for continuity of care and wellness. Decisions that are made about lower income patients' care must be sensitive to the differing degrees of access to resources.

The role of religious beliefs

- Religious beliefs can often influence a patient's decision about medical treatment. Because of their religious faiths, patients may request diagnosis but not treatment. If a particular treatment is absolutely necessary, Providers may find it helpful to consult with the patient's spiritual leader. Patients who seek mainstream medical care may also seek treatment from healers in their culture. Rather than discouraging this, especially if the alternative treatment is not harmful, Providers and their staff may want to incorporate traditional healing into the general treatment plan.

The role of the family

- Traditional cultures place a greater emphasis on the role of the family. Decision-making about health issues may be a family affair. It can be helpful for Providers and their staff to take this into account as medical decision-making takes place.
- Questions to consider:
 1. How many family members can accompany the patient into the room?
 2. Should friends be allowed in the room?
 3. Who can or should be told about the patient's condition?

SECTION THREE

STRATEGIES AND APPROACHES IN ASSESSING PATIENT'S BELIEFS ABOUT HEALTH AND ILLNESS

Cultural assessment

Cultural assessment of the patient is an important step in identifying the patient's views and beliefs related to health and illness. Beliefs about the cause, prevention, and treatment of illness vary among cultures. Such beliefs dictate the practices used to maintain health. Studies have classified Health Practices into several categories: **folk practices, spiritual or psychic healing practices, and conventional medical practices.**

In addition to the general data collected from a patient, the following checklist may be helpful in gaining culturally specific information.

- Where were you born?
- If you were born outside the USA, how long have you lived in this country?
- Who are the people you depend upon the most for help? (Family members, friends, community services, church etc.)
- Are there people who are dependent on you for care? Who are they? What kind of care do you provide?
- What languages do you speak?
- Can you read and write in those languages?
- What is the first thing you do when you feel ill?
- Do you ever see a native healer or other type of practitioner when you don't feel well?
- What does that person do for you?
- Do you ever take any herbs or medicines that are commonly used in your native country or cultural group?
- What are they, and what do you take them for?
- What foods do you generally eat? How many times a day do you eat?
- How do you spend your day?
- How did you get here today?
- Do you generally have to arrange for transportation when you have appointments?

Cultural assessment (continued)

To help Providers and their staff conduct cultural assessments, the questionnaire below will help determine a patient's beliefs about his or her problem:

Tools To Elicit Health Beliefs

1. What do you call your problem? What name does it have?
2. What do you think caused your problem?
3. Why do you think it started when it did?
4. What does your sickness do to you? How does it work?
5. How severe is it? Will it have a short or long course?
6. What do you fear most about your disorder?
7. What are the chief problems that your sickness has caused for you?
8. What kind of treatment do you think you should receive? What are the most important results you hope to receive from treatment?

Further Questions to Consider

- Do individuals in this culture feel comfortable answering questions?
- When the Provider asks questions, does the patient, or family, perceive this as a lack of knowledge?
- Who should be told about the illness?
- Does the family need a consensus or can one person make decisions.
- Does the patient feel uncomfortable due to the gender of the Provider?
- Does more medicine mean more illness to the patient?
- Does no medication mean healthy?
- Does the patient prefer to feel the symptoms, or mask them?
- Does the patient prefer ONE solution or choices of treatment?
- Does the patient want to hear about risks?

(Source: Kleinman, Arthur A. Patients and Healers in the Context of Culture. The Regents of the University of California. 1981.

SECTION FOUR

EFFECTIVE PATIENT COMMUNICATION AND EDUCATION STRATEGIES

Communication

Intercultural communication is a key clinical issue in medicine and can determine quality of care. The language barrier is a particularly serious problem for Providers and patients alike. Since effective communication between patients and Providers is necessary for positive outcomes, the use of translators is essential.

Even with English speaking populations, it can be a challenge for the patient to try to understand the medical jargon that is commonplace among professionals in the healthcare setting. For example, words like “diet” have different meanings to professionals than they have in the general public.

Other Factors Influencing Communication:

- Conversational style: It may be blunt, loud and to the point – or quiet and indirect.
- Personal space: People react to others based on their cultural conceptions of personal space. For example, standing “too close” may be seen as rude in one culture and appropriate in another.
- Eye contact: In some cultures, such as Native American and Asian, avoiding direct eye contact may be a sign of respect and represents a way of honoring a person’s privacy.
- Touch: A warm handshake may be regarded positively in some cultures, and in others, such as some Native American groups, it is viewed as disrespectful.
- Greeting with an embrace or a kiss on the cheek is common among some cultures.
- Response to pain: People in pain do not always express the degree of their suffering. Cultural differences exist in patient’s response to pain. In an effort to “be a good patient” some individuals may suffer unnecessarily.
- Time orientation: Time is of the essence in today’s medical practice. Some cultural groups are less oriented to “being on time” than others.

Other Factors Influencing Communication (Continued):

What's in a name:

Some patients do not mind being called by their first name; others resent it. Clarify the patient's preference early on in the patient-Provider relationship.

Nonverbal communication:

Messages are communicated by facial expressions and body movements that are specific to each culture. Be aware of variations in non-verbal communication to avoid misunderstandings.

When English is a second language:

According to the US Census Bureau, 14% of Americans speak a language other than English in their home and 6.7 million people have limited or no English skills. As these numbers continue to grow, the need for multilingual care becomes more significant.

Patients with limited English proficiency may have more difficulty expressing thoughts and concerns in English and may require more time and patience. It is best to use simple vocabulary and speak slowly and clearly. Do not assume that because the patient can speak English that he can read and write in English as well. Remember, just because somebody speaks with a "perfect" American accent, doesn't mean that they will have complete and full mastery of the English language.

Translators:

Often, volunteers from the community or relatives are brought by the patient to help with translation. Since patients may be reluctant to confide personal problems with non-professionals and may leave out important facts, this practice should be discouraged. Realize that it may be difficult for patients to discuss personal issues in front of a third non-professional party. The use of employees as translators (secretaries, house keeping etc.) may not be a better solution.

Translators should understand and speak a language well enough to manage medical terminology. The ideal translator is a professional. If a professional translator is not available, over the phone translation services can be used.

Enhancing cross-cultural communication

- Communicate effectively: Allow more time for cross-cultural communication, use translators who are not family members and ask questions about cultural beliefs.
- Understand differences: Realize that family integration is more important than individual rights in many cultures. Involve spiritual or religious advisors when appropriate. Be aware of your own cultural beliefs and biases. Be sensitive to your authority as a medical professional.
- Identify areas of potential conflict: Determine who is the appropriate person to make decisions and clarify and discuss important ethical disagreements with them.
- Compromise: Show respect for beliefs that are different from your own. Be willing to compromise about treatment goals or modalities whenever possible. Remember that taking care of patients from other cultures can be time-consuming and challenging. In almost all instances, however, the extra time and effort expended will result in more satisfied patients, families and professionals.

SECTION FIVE

CULTURAL RESOURCES AND INTERPRETATION/TRANSLATION SERVICES

ALL AHCCCS contracted Health Plans and Program Contractors provide a variety of cultural competency resources, including interpretation/translation services and cultural awareness training. Under the AHCCCS program, these organizations are required to provide interpretation/translation services to Providers and Members free of charge.

If you need interpretation/translation services for patient care or wish to receive more information about available cultural competency resources, please contact the patient's AHCCCS Health Plan or Program Contractor to make the necessary arrangements.

AHCCCS and its participating Health Plans and Program Contractors encourage you to use professional interpretation/translation services. Use of non-professional interpretation/translation services such as by bilingual staff and/or a patient's family member may jeopardize patient outcomes.

INTERNET Resources

There are many cultural competency resources available on the Internet. The following listing is intended for informational purposes only.

General Reference sites:

- AMA Cultural Competence Initiative - <http://www.ama-assn.org/ethic/diversity/>
- National Center for Cultural Competence: Bureau of Primary Health Care Component <http://www.dml.georgetown.edu/depts/pediatrics/gucdc/nccc.html>. Home page <http://www.dml.georgetown.edu/depts/pediatrics/gucdc/cultural.html>
- Ethnomed: University of Washington: cultural profiles, cross cultural topics, patient education <http://healthlinks.washington.edu/clinical/ethnomed/>
- http://www.baylor.edu/~Charles_Kemp/hispanic_health.htm Great site for information on Hispanic and other cultures (i.e. Bosnian refugees).

General Reference sites (continued):

- Society of Teachers of Family Medicine: Multicultural Health Care and Education <http://stfm.org/corep.html>. General curriculum information and listings of print, experiential exercises, games, simulations and video resources (not online). STFM homepage <http://stfm.org/index.html>
- AMSA (American Medical Student Association): <http://www.amsa.org/programs/gpit/cultural.htm>
- Cross Cultural Health Care Program (CCHCP) Site offers schedules/location/fees of cultural competency training, interpreter training, research projects, community collaboration, and other services. Online registration for training sessions, interpreter and translation services. <http://www.xculture.org/>
- Opening Doors: in progress - cultural issues of health care -will contain discussion forum on cultural issues in healthcare, articles, etc. <http://www.opening-doors.org/>
- Perspective of Difference: an interactive teaching module <http://medicine.ucsf.edu/divisions/dgim/pods/html/main.html>
- Bridge to Wellness: Cultural Competency <http://www.serve.com/Wellness/culture.html>. Homepage: www.serve.com/Wellness -Developed for Adult Psychiatry- list of cultural competency principles for health care clinicians.
- U.S. Department of Health and Human Services: The Initiative to Eliminate Racial and Ethnic Disparities in Health <http://raceandhealth.hhs.gov/>
- National Institute of Health Office of Research on Minority Health <http://www1.od.nih.gov/ormh/main.html>
- Health and Human Services: Health Resources and Services Admin.: news articles <http://www.hrsa.dhhs.gov/>
- US Department of Health and Human Services: Office of Public Health and Sciences: Office of Minority Health Resource Center <http://www.omhrc.gov/>
- Bureau of Primary Health Care Supported Community Health Programs <http://www.bphc.hrsa.dhhs.gov/databases/fqhc/fqhquery.cfm>
- The Center for Cross Cultural Health: (410 Church street, Suite W227, Minneapolis, MN 55455) <http://www.umn.edu/ccch/>
- Cross Cultural Health Care Program (Pacific Medical Clinics / 1200 12th Avenue South, Seattle, WA 98144-2790 / Phone: (206) 326-4161) <http://www.xculture.org/>
- Department of Health and Human Services / Health Resources and Services Administration / Bureau of Primary Health Care (4350 East-West Highway, Bethesda, MD 20814)
- Interface International: Provides publications and training tools (c/o Suzanne Salimbene, Ph.D. / 3821 East State Street, Suite 197, Rockford, IL 61108 / Phone: (815) 965-7535 / e-mail: IF4YOU@aol.com)
- Simulation Training System (218 Twelfth Street, Del Mar, CA 92014-0901) / Resources for Cross-cultural Health Care: <http://www.diversityrx.org/>
- National Urban League (Phone: 212-310-9000) or <http://www.nul.org/>
- African Community Health and Social League (Phone: (510) 839-7764) <http://www.progway.org/ACHSS.html>

General Reference sites (continued):

- Association of Asian Pacific Community Health Organizations (Phone: (510) 272-9536)
<http://www.aapcho.org>
- National Coalition of Hispanic Health and Human Services Organizations / Phone: (202) 387-5000
<http://www.cossmho.org>
- Center for American Indian and Alaskan Native Health Phone: (410) 955-6931 / <http://ih1.sph.jhu.edu/cnah/>
www.culturalorientation.net or www.erc.msh.org "Providers Guide to Quality and Culture)

APPENDIX J:

DES/DDD PEER REVIEW POLICY

200 Peer Review

201 Purpose

The purpose of this policy is to define a process to review and maintain high standards of health care services delivered by health care professionals serving persons with developmental disabilities in a fee-for service capacity, or as a health care professional associated with a Division of Developmental Disabilities (Division) contracted Health Plan. Referrals of potential quality of care issues may be received from external sources (such as provider agencies, consumers and their families, Arizona Health Care Cost Containment System (AHCCCS) or subcontracted Health Plans), through support coordination or tracking and trending identified by the Risk Incident Management System (RIMS).

202 Definitions

Quality of Care: The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Peer review: Evaluation of the necessity, quality or utilization of care/service provided by a health care professional/provider.

Conducted by other health care professionals/providers from the same discipline or with similar or essentially equal qualifications who are not in direct economic competition with the health care professional under review.

Compares the health care professional/provider's performance with that of peers or with community standards of care/service.

Severity Level Definitions:

Level 0 – No quality issue identified

Level 1 – Potential quality of care concern identified, but the incident did not cause harm to the consumer

Level 2 – Potential quality of care concern identified, the incident caused nonpermanent harm to the consumer

Level 3 – Potential quality of care concern identified, the incident caused permanent harm to the consumer

Level 4 – Potential quality of care concern identified, the incident caused death of the consumer.

Corrective actions and reporting to regulatory agencies will be taken as appropriate for all levels of severity.

203 Policy

The Division reviews potential quality of care issues using physician and peer review with the assistance of the Quality Management Administrator.

All leveling decisions are made by physicians.

Written correspondence regarding quality of care decisions is executed by the Division's Medical Director.

Investigations conducted through the peer review process are strictly confidential, conducted during Executive session during the Quality Management Clinical Quality Council Committee, and are provided immunity from discover pursuant to the provisions of A.R.S. 36-2401 et. seq., and A.R.S. 36-2917 et. seq.

The Division meets all Health Insurance Portability and Accountability Act (HIPAA) requirements related to the management of Protected Health Information (PHI).

The Peer Review Committee is chaired by the Division's Medical Director. Peer review activities are conducted in Executive session during the Clinical Quality Council (CQC) meeting. Although peer review is scheduled during CQC meeting, which meets monthly, the Division will schedule peer review as required to meet the needs of the Division; however no less than quarterly. Any member of the peer review team is required to excuse himself/herself if there is a direct or indirect conflict of interest. The peer review committee will include a provider of the same or similar specialty. Peer review functions to improve clinical care services. It includes, but is not limited to:

- Reviewing Quality of Care Concerns, especially those involving;
 1. Substantiated abuse, neglect, exploitation, or unexpected death.
 2. Statewide significance.
 3. High profile issues of care.
- Reviewing the quality of services to insure that services meet or exceed the standard of care of those services in the community;
- Reviewing apparent negative outcomes of service delivery; and
- Reviewing client or interagency concerns regarding services delivered.
- The peer review committee will evaluate cases referred to peer review based on all information made available through the quality management process.

Referrals to regulatory agencies will not be limited to cases taken to peer review. Referrals will be made as appropriate based on the outcome of quality of care determinations.

204 Referrals/Procedure

- A. Referrals may be initiated by anyone who becomes aware of a potential issue involving quality of care or the appropriate use of medical resources by a health care professional, i.e., physician, physician's assistant, nurse practitioner, dentist, nurse, etc.
- B. Referrals may also result from the Risk Incident Management System (RIMS) reports, care concerns, grievance process, or complaint process.
- C. Quality of care cases should be brought to the attention of the Medical Director or Quality Management Administrator.
- D. If the concern relates to a provider associated with a contracted Health Plan, the Medical Director or Quality Management Administrator will forward the concern directly to the Division's Health Care Services Administrator. The concern will then be forwarded to the contracted Health Plan for evaluation and investigation. The Medical Director for the Division of Developmental Disabilities is a voting member of the peer review committee for each of the sub-contracted health plans and will conduct peer review activities in concert with the health plan physicians. Findings will be presented during the Division's Peer review committee meeting. The peer review committee must evaluate cases referred to peer review based on all information made available through the quality management process per AMPM Chapter 900, policy 910. 4-e.
- E. Concerns associated with Behavioral Health Services will be forwarded to the Division's Behavioral Health Unit Manager. The Behavioral Health Unit Manager will then forward the concern to the Division of Behavioral Health Services for evaluation and investigation. The outcome of the evaluation and investigation will be reviewed by the Division's Medical Director. The Division is responsible for ensuring a comprehensive review/research/investigation is completed on all quality of care concerns referred to the Division of Behavioral Health through the Division's quality management process. The peer review committee must evaluate cases referred to peer review based on all information made available through the quality management process per AMPM Chapter 900, policy 910. 4-e.
- F. Concerns not associated with the subcontracted health plans or Behavioral Health Services will be forwarded to the Medical Director and the Quality Management Administrator. The Division will request all records associated with the concern. The Quality Management Administrator will perform a focused review to identify evidence of potential concerns based on expected quality of care delivery and prepare a short case summary

highlighting the evidence pertinent to the concern. The records and the summary will then be provided to the Division's Medical Director for further review and consultation as needed. The Medical Director will assign a quality severity level. The peer review committee must evaluate cases referred to peer review based on all information made available through the quality management process per AMPM Chapter 900, policy 910. 4-e.

- G. The Medical Director will aggregate and summarize the findings at the next scheduled Clinical Quality Council in executive session (minutes will identify the Clinical Quality Council is now in executive session and will be signed and dated), which will constitute the Peer Review Committee. Outside experts may be invited to participate in the Peer Review meeting and answer questions from the committee. If the records being reviewed directly pertain to a member of the committee, or present a conflict of interest for the member, he/she will be excluded from the executive session. Consumers or providers discussed during Peer review will be identified in the minutes as A, B, C, rather than by initials.
- H. The Committee will make recommendations to improve care when problems are identified. Types of corrective actions may include:
 - I. Education
 - II. Follow-up monitoring and evaluation of the provider
 - III. Changes in processes, structures, or forms
 - IV. Informal counseling
 - V. Corrective Action Plan and/or sanctioning of the provider.
 - VI. Procedures for terminating the affiliation with the health care professional.
 - VII. Referral to licensing agency, i.e. Board of Medical Examiners, Board of Pharmacy, Board of Nursing, Department of Health Services, etc.
 - VIII. Placing a cap on enrollment.

For Level 0 cases, a letter to the provider will be sent, outlining review findings. Case will be closed.

For Level 1 cases, a letter to the provider will be sent, outlining a review of the findings. A corrective action plan may be requested at the discretion of the Medical Director.

For Level 2 – 4 cases, a second review may be conducted, additional information may be requested from the provider or an outside specialty physician review may be requested.

The provider will receive documentation of the findings and recommendations of the Committee and will have the opportunity to review and respond, in writing, to the Medical Director. **A provider may request an appeal of any recommendations that**

adversely affect the provider's credentials or contract with the Division. The provider has thirty (30) days to respond. At that time, final recommendations will then be made to the DES/DDD Assistant Director for final action.

Recommendations for reporting to government and regulatory boards will be forwarded to the Quality Management Committee for review and action.

205 Confidentiality/Immunity

- A. All information generated by the Peer Review Process shall be kept confidential. The Peer Review records must be made available to AHCCCS Quality Management upon request.

- B. Peer review materials include, but are not limited to:
 - I. Peer review referrals.
 - II. Medical records from all sources relevant to the investigation.
 - III. Medical Director's correspondence related to case, referral or health professional.
 - IV. Outcomes or findings of review.
 - V. Reports to or from appropriate licensing agencies.
 - VI. Unusual incident reports
 - VII. Grievances
 - VIII. Investigative findings.