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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

Medical Director
Robert Klaehn, M.D. 602/542-6826 phone
602/364-1322 Fax

Administrator
Louette Coulson, RN, BSHS 602/238-9028 x6012

**Medical Services**
Annette Lammon-Belcher, R.N. - Manager Ext: 6035

EPSDT Coordinator
Darlene Carreras Ext. 6034

Prior Authorization – **FEE-FOR-SERVICE**
Annette Lammon-Belcher, R.N. – Manager Ext. 6035

Maternal Child Health
Annette Lammon-Belcher, R.N. – Manager Ext. 6035

**Ventilator Program**
Hanna Alzen, R.N. – Manager 602/238-9028 Ext. 6016

**Provider Relations**
Beth Gonzales, LPN, Supervisor 602/238-9028 x6010
Donna Badagliacqua, RN 602/238-9028 x6026
Tobie Trejo, LPN 928/707-1350

**Member Services**
Alice Gonzales 602/238-9028 x6029
DES/DDD Acute Care Claims Department
   Michelle Goeglein, Manager 602/542-6890 phone
   602/542-8193 Fax

DES/DDD Early Childhood Coordinator
   Linda Tasco 602-542-6829 phone
   602/364-1322 Fax
   1789 W. Jefferson
   Phoenix, AZ 85005

Behavioral Health
   Tyrone Peterson, Behavioral Health Manager 602/364-2852
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.

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<th>Name/Status</th>
<th>Instructions</th>
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<td>Provider’s name, address, and phone number.</td>
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<td>2.</td>
<td>Pay –To-Name and Address</td>
<td>The address that the provider submitting the bill intends payment to be sent if different than that of the Billing Provider (See #1)</td>
</tr>
<tr>
<td>3.a</td>
<td>Patient Control No.</td>
<td>Account or bill control number assigned by provider. DES/DDD will return this number as a cross reference on Remittance Advice.</td>
</tr>
<tr>
<td>3.b*</td>
<td>Medical/Health Record Number</td>
<td>This is the number assigned to the patient’s medical/health record by the provider.</td>
</tr>
<tr>
<td>Field</td>
<td>Name/Status</td>
<td>Instructions</td>
</tr>
<tr>
<td>-------</td>
<td>------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>4.</td>
<td>Bill Type</td>
<td>Facility type (1st digit), bill classification (2nd digit), and frequency (3rd digit). See UB04 Manual for codes.</td>
</tr>
<tr>
<td>7.</td>
<td>Reserved</td>
<td>Not currently in use.</td>
</tr>
<tr>
<td>8.a-e</td>
<td>Patient Name/Identifier</td>
<td>Last name, first name and middle initial of the patient and the patient identifier as assigned by payer.</td>
</tr>
<tr>
<td>9.*</td>
<td>Patient Address</td>
<td>The mailing address of the patient.</td>
</tr>
<tr>
<td>10.*</td>
<td>Patient Birth Date</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Patient Sex</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Admission/Start of Care Date</td>
<td>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.</td>
</tr>
<tr>
<td>13.*</td>
<td>Admission Hour</td>
<td>The code referring to the hour during which the patient was admitted for inpatient or outpatient care.</td>
</tr>
<tr>
<td>14.</td>
<td>Priority (Type) of Visit (Inpatient only)</td>
<td>A code indicating the priority of the admission/visit. See UB-04 Manual for codes.</td>
</tr>
<tr>
<td>15.</td>
<td>Source of Referral for Admission or Visit (Inpatient only)</td>
<td>A code indicating the source of the referral for this admission or visit. See UB-04 Manual for codes.</td>
</tr>
<tr>
<td>17.</td>
<td>Patient Discharge Status (Inpatient Only)</td>
<td>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.</td>
</tr>
<tr>
<td>18-28.</td>
<td>Condition Codes:</td>
<td>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.</td>
</tr>
<tr>
<td>Field</td>
<td>Name/Status</td>
<td>Instructions</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
<td>--------------</td>
</tr>
<tr>
<td>29*</td>
<td>Accident State</td>
<td>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.</td>
</tr>
<tr>
<td>30.</td>
<td>Reserved</td>
<td>Not currently in use.</td>
</tr>
<tr>
<td>31-34*</td>
<td>Occurrence Codes and Dates</td>
<td>The code and associated date defining a significant event relating to this bill that may affect payer processing. See UB-04 Manual for codes.</td>
</tr>
<tr>
<td>35-36*</td>
<td>Occurrence Spans Codes and Dates</td>
<td>A code or related dates that identify an event that relates to the payment of the claim. See UB-04 Manual for codes.</td>
</tr>
<tr>
<td>37.</td>
<td>Reserved</td>
<td>Not currently used.</td>
</tr>
<tr>
<td>38*</td>
<td>Responsible Party Name and Address</td>
<td>Responsible party name and address. The name and address of the party responsible for the bill.</td>
</tr>
<tr>
<td>39-41*</td>
<td>Value Codes and Amounts</td>
<td>A code structure to relate amounts or values to data elements necessary to process this claim as qualified by the payer organization. See UB-04 Manual for codes.</td>
</tr>
<tr>
<td>42.</td>
<td>Revenue Codes</td>
<td>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.</td>
</tr>
<tr>
<td>43.</td>
<td>Revenue Code Description</td>
<td>Refer to the UB-04 Manual for description of revenue codes.</td>
</tr>
<tr>
<td>44.</td>
<td>HCPCS/Rates/Accommodation Rates</td>
<td>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.</td>
</tr>
<tr>
<td>45*</td>
<td>Service Date (outpatient)</td>
<td>Enter the date (MMDDYY) the outpatient service was provided.</td>
</tr>
<tr>
<td>46.</td>
<td>Service Units</td>
<td>If accommodation days are billed, number of units billed, or for items such as dialysis treatments, pints of blood, etc.</td>
</tr>
<tr>
<td>47.</td>
<td>Total Charges</td>
<td>Total charges obtained by multiplying units of service by</td>
</tr>
<tr>
<td>Field</td>
<td>Name/Status</td>
<td>Instructions</td>
</tr>
<tr>
<td>-------</td>
<td>----------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>unit charge for each revenue code. Each line other than sum of all charges may include charges up to $999,999.99.</td>
</tr>
<tr>
<td>48.*</td>
<td>Non-Covered Charges</td>
<td>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.</td>
</tr>
<tr>
<td>49.</td>
<td>Reserved</td>
<td>Not required.</td>
</tr>
<tr>
<td>50.*</td>
<td>Payer Name</td>
<td>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.</td>
</tr>
<tr>
<td>51.</td>
<td>Health Plan ID#</td>
<td>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.</td>
</tr>
<tr>
<td>52.</td>
<td>Release of Information</td>
<td>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.</td>
</tr>
<tr>
<td>53.</td>
<td>Assignment of Benefits Certification Indicator</td>
<td>Required.</td>
</tr>
<tr>
<td>54.*</td>
<td>Prior Payments</td>
<td>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.)</td>
</tr>
<tr>
<td>55.</td>
<td>Estimated Amount Due</td>
<td>The amount estimated by the provider to be due from the indicated payer.</td>
</tr>
<tr>
<td>56.</td>
<td>National Provider Identifier (NPI)</td>
<td>Required</td>
</tr>
<tr>
<td>57.a</td>
<td>Other (Billing) Provider Identifier</td>
<td>Required if applicable Enters AHCCCS # for atypical providers.</td>
</tr>
<tr>
<td>58.</td>
<td>Insured’s Name</td>
<td>Enter name of insured covered by payer in Field 50.</td>
</tr>
<tr>
<td>Field</td>
<td>Name/Status</td>
<td>Instructions</td>
</tr>
<tr>
<td>---------</td>
<td>--------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>59.</td>
<td>Patient’s Relationship (A-C) to insured.</td>
<td>Enter relationship of recipient to insured.</td>
</tr>
<tr>
<td>60.</td>
<td><strong>Insured’s Unique Identifier (AHCCCSID)</strong></td>
<td>The unique number assigned to the Health Plan to the insured. Required.</td>
</tr>
<tr>
<td>61.</td>
<td>Insured’s Group Name</td>
<td>Enter insured’s group name or “FFS” for AHCCCS or ALTCS recipients not enrolled in a plan.</td>
</tr>
<tr>
<td>62.</td>
<td>Insurance Group Number</td>
<td>Leave blank for Fee-For-Service recipients.</td>
</tr>
<tr>
<td>63.</td>
<td>Treatment Authorization Code</td>
<td>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.</td>
</tr>
<tr>
<td>64.</td>
<td>Document Control Number (DCN)</td>
<td>A control # number assigned to the original bill.</td>
</tr>
<tr>
<td>65.</td>
<td>Employer Name</td>
<td>Enter name of insured’s employer.</td>
</tr>
<tr>
<td>66.</td>
<td>Diagnosis and Procedure Code Qualifier (ICD)</td>
<td>The qualifier that denotes the version of International Classification of Diseases (ICD) reported.</td>
</tr>
<tr>
<td>67.a-q</td>
<td><strong>Principal Diagnosis and Other Diagnosis Codes</strong></td>
<td>Enter principal ICD-9 diagnosis code. (Code should match diagnosis code listed on DES/DDD Prior Authorization if obtained.)</td>
</tr>
<tr>
<td>68.</td>
<td>Reserved</td>
<td>Not currently used.</td>
</tr>
<tr>
<td>69.</td>
<td><strong>Admitting Diagnosis</strong></td>
<td>Required for inpatient bills. Enter ICD-9 diagnosis code that represents significant admitting diagnosis.</td>
</tr>
<tr>
<td>70. a-c</td>
<td>Patient’s Reason for Visit (Outpatient Only).</td>
<td></td>
</tr>
<tr>
<td>71.</td>
<td>Prospective Payment System (PPS) Code</td>
<td></td>
</tr>
<tr>
<td>72* a-c</td>
<td><strong>External Cause of Injury (ECI) Code</strong></td>
<td>The ICD-9 diagnosis codes pertaining to external cause of injuries, poisoning, or adverse effect.</td>
</tr>
<tr>
<td>73.</td>
<td>Reserved</td>
<td>Currently not used.</td>
</tr>
<tr>
<td>Field</td>
<td>Name/Status</td>
<td>Instructions</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>74.a-e</td>
<td>Principal and Other Procedure Codes and Dates</td>
<td>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.</td>
</tr>
<tr>
<td>75.</td>
<td>Reserved</td>
<td>Currently not used.</td>
</tr>
<tr>
<td>76.*</td>
<td>Attending Provider Name and Identifier (NPI)</td>
<td></td>
</tr>
<tr>
<td>77*.</td>
<td>Operating Physician Name and Identifier (NPI)</td>
<td>The name and identification number of the individual with the primary responsibility for performing surgical procedures. Required if surgical code is listed on claim.</td>
</tr>
<tr>
<td>78.-79</td>
<td>Other Provider Name and Identifiers (NPI)</td>
<td>Name and Identifiers (NPI).</td>
</tr>
<tr>
<td>80*</td>
<td>Remarks Field</td>
<td>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.</td>
</tr>
<tr>
<td>81*</td>
<td>Code</td>
<td>Code Field to report additional codes related to a Form Locator (overflow) or to report externally maintained codes approved by NUBC. See UB04 Manual.</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Field</th>
<th>Name/Status</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Program Block</td>
<td>Check second box labeled “Medicaid”.</td>
</tr>
<tr>
<td>1a.</td>
<td>Insured’s ID Number</td>
<td>Enter recipient’s HCS ID number. If there are questions about eligibility of the HCS ID number, call DES/DDD Member Services.</td>
</tr>
<tr>
<td>2.</td>
<td>Patient Name</td>
<td>Enter recipient’s last name, first name, and middle initial as they appear on the HCS ID card.</td>
</tr>
<tr>
<td>3.</td>
<td>Patient Birth Date and Sex</td>
<td>Enter recipient’s date of birth and Sex. Check appropriate box to indicate patient’s gender.</td>
</tr>
<tr>
<td>4.</td>
<td>Insured’s Name</td>
<td>Enter “Same” to indicate that insured and recipient name in Field 2 are same.</td>
</tr>
<tr>
<td>5.</td>
<td>Patient Address</td>
<td>Enter recipient’s address as street, city, state, and zip code. Enter area code and telephone number.</td>
</tr>
<tr>
<td>6.</td>
<td>Patient Relation to Insured</td>
<td>Not required.</td>
</tr>
<tr>
<td>7.</td>
<td>Insured Address</td>
<td>Not required.</td>
</tr>
<tr>
<td>8.</td>
<td>Patient Status</td>
<td>Check boxes that represent recipient’s marital status, employment, and student status.</td>
</tr>
<tr>
<td>9.*</td>
<td>Other Insured’s Name</td>
<td>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.</td>
</tr>
<tr>
<td>9a.*</td>
<td>Other Insured’s Group Number</td>
<td>Enter group number of other insurance.</td>
</tr>
<tr>
<td>9b.</td>
<td>Other Insured’s DOB/Sex</td>
<td>If the other insured is not the ALTCS recipient, complete this block.</td>
</tr>
<tr>
<td>Field</td>
<td>Name/Status</td>
<td>Instructions</td>
</tr>
<tr>
<td>-------</td>
<td>---------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>9c.</td>
<td>Other Insured’s Employer/School</td>
<td>Enter name of organization through which insurance is obtained, such as employer of insured or school that makes insurance available.</td>
</tr>
<tr>
<td>9d.*</td>
<td>Insurance Plan or Program Name</td>
<td>Enter name of insurance company or program name that provides the insurance coverage.</td>
</tr>
<tr>
<td>10.*</td>
<td>Relation of (A-C) Patient Condition</td>
<td>Check appropriate box to indicate if recipient’s condition is result of employment, auto accident, or other type of accident.</td>
</tr>
<tr>
<td>10d.</td>
<td>Reserved</td>
<td>Not currently in use.</td>
</tr>
<tr>
<td>11.</td>
<td>Insured’s Group Policy or FECA #</td>
<td>If recipient is a newborn, enter mother’s HCS ID number.</td>
</tr>
<tr>
<td>11a.</td>
<td>Insured’s DOB/Sex</td>
<td>Not required.</td>
</tr>
<tr>
<td>11b.</td>
<td>Employer’s Name or School Name</td>
<td>Not required.</td>
</tr>
<tr>
<td>11c.</td>
<td>Insurance Plan Name or Program Name</td>
<td>Not required.</td>
</tr>
<tr>
<td>11d.*</td>
<td>Other Health Benefit</td>
<td>Check appropriate box to indicate other health benefit.</td>
</tr>
<tr>
<td>12.</td>
<td>Patient or Authorized Person’s Signature</td>
<td>Recipient’s signature will authorize release of medical or treatment data.</td>
</tr>
<tr>
<td>13.</td>
<td>Insured’s/Authorized Person’s Signature</td>
<td>Not required.</td>
</tr>
<tr>
<td>14.*</td>
<td>Date of Illness or Injury</td>
<td>Enter date of onset of symptoms or date of injury, if available.</td>
</tr>
<tr>
<td>15.</td>
<td>Date of Same or Similar Illness</td>
<td>Not required.</td>
</tr>
<tr>
<td>17.*</td>
<td>Name of Referring Physician</td>
<td>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”.</td>
</tr>
<tr>
<td>Field</td>
<td>Name/Status</td>
<td>Instructions</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>17a.</td>
<td>ID of Referring Provider</td>
<td>(Required only for podiatry services.)</td>
</tr>
<tr>
<td>17b.</td>
<td>NPI of Referring Provider (shaded area)</td>
<td>(Required only for podiatry services)</td>
</tr>
<tr>
<td>18.</td>
<td>Hospitalization Dates</td>
<td>For hospitalized recipients, enter From and Through dates of hospitalization related to service billed on this claim.</td>
</tr>
<tr>
<td>19.</td>
<td>Reserved for Local Use</td>
<td>Not required.</td>
</tr>
<tr>
<td>20.</td>
<td>Outside Lab</td>
<td>Check appropriate box to indicate whether outside lab work was performed as part of service. If “Yes” is checked, enter charge for these services.</td>
</tr>
<tr>
<td>21.</td>
<td>Diagnosis Codes</td>
<td>Enter up to four ICD-9 diagnosis codes appropriate to recipient’s condition. Only ICD-9 codes will be accepted. Written description is optional.</td>
</tr>
<tr>
<td>22.*</td>
<td>Medicaid Resubmission Code</td>
<td>Enter appropriate code to indicate whether claim is an adjustment or void of paid claim or resubmission of denied claim:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A    Adjustment of paid claim</td>
</tr>
<tr>
<td></td>
<td></td>
<td>V    Void of paid claim</td>
</tr>
<tr>
<td></td>
<td></td>
<td>R    Resubmission of denied claim</td>
</tr>
</tbody>
</table>

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.

For voids, enter “V”. Submit only those claim lines to be voided.

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.
<table>
<thead>
<tr>
<th>Field</th>
<th>Name/Status</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Claims to be voided or adjusted must have been paid by DES/DDD. Claim resubmissions must have been denied by DES/DDD.</td>
</tr>
<tr>
<td>23.</td>
<td>Prior Authorization</td>
<td>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.</td>
</tr>
<tr>
<td>24A.</td>
<td>Date of Service</td>
<td>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).</td>
</tr>
<tr>
<td>24B.</td>
<td>Place of Service</td>
<td>Enter the code that describes the place of service:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11 Office</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12 Patient’s residence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>21 Inpatient hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>22 Outpatient hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>23 Emergency room - hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>24 Ambulatory surgical center</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25 Birthing Center</td>
</tr>
<tr>
<td></td>
<td></td>
<td>26 Military treatment facility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>31 Skilled nursing facility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>32 Nursing facility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>33 Custodial care facility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>34 Hospice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>41 Ambulance - land</td>
</tr>
<tr>
<td></td>
<td></td>
<td>42 Ambulance - air or water</td>
</tr>
<tr>
<td></td>
<td></td>
<td>51 Inpatient psychiatric facility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>52 Psychiatric facility partial hospitalization</td>
</tr>
<tr>
<td></td>
<td></td>
<td>53 Community mental health center</td>
</tr>
<tr>
<td></td>
<td></td>
<td>54 Intermediate care facility/mentally retarded (ICF/MR)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>55 Residential substance abuse treatment facility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>61 Comprehensive inpatient rehabilitation facility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>62 Comprehensive outpatient rehabilitation facility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>65 End stage renal disease treatment facility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>71 State or local public health clinic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>72 Rural health clinic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>81 Independent laboratory</td>
</tr>
<tr>
<td></td>
<td></td>
<td>99 Other unlisted facility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: Non-emergency transportation providers should use “99”.</td>
</tr>
<tr>
<td>Field</td>
<td>Name/Status</td>
<td>Instructions</td>
</tr>
<tr>
<td>--------</td>
<td>---------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>24C*</td>
<td>EMG – Emergency Indicator</td>
<td>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.</td>
</tr>
<tr>
<td>24D</td>
<td>Procedure, Services Or Supplies</td>
<td>Enter HCPCS/CPT procedure code that identifies the service provided. Enter procedure modifier if appropriate.</td>
</tr>
<tr>
<td>24E</td>
<td>Diagnosis</td>
<td>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.</td>
</tr>
<tr>
<td>24F</td>
<td>Charges</td>
<td>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.</td>
</tr>
<tr>
<td>24G</td>
<td>Units</td>
<td>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.</td>
</tr>
<tr>
<td>24H</td>
<td>EPSDT/ Family Planning</td>
<td>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.</td>
</tr>
<tr>
<td>24I*</td>
<td>ID Qualifier.</td>
<td></td>
</tr>
<tr>
<td>24J*</td>
<td>COB (Shaded Area)</td>
<td>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.</td>
</tr>
<tr>
<td>Field</td>
<td>Name/Status</td>
<td>Instructions</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>25.</td>
<td>Federal Tax ID</td>
<td>Required.</td>
</tr>
<tr>
<td>26.</td>
<td>Patient’s Account Number</td>
<td>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.</td>
</tr>
<tr>
<td>27.</td>
<td>Accept Assignment</td>
<td>Not required.</td>
</tr>
<tr>
<td>28.</td>
<td>Total Charges</td>
<td>Enter total for all charges for all lines on claim.</td>
</tr>
<tr>
<td>29.*</td>
<td>Amount Paid</td>
<td>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.</td>
</tr>
<tr>
<td>30.</td>
<td>Balance Due</td>
<td>Enter balance due by subtracting sum of payments in Field 29 from total charges.</td>
</tr>
<tr>
<td>31.</td>
<td>Signature</td>
<td>Claim must be signed by provider or authorized representative. Rubber stamp signatures are acceptable if initialed by provider representative.</td>
</tr>
<tr>
<td></td>
<td>Date</td>
<td>Enter date on which claim was signed.</td>
</tr>
<tr>
<td>32.</td>
<td>Name and Address of Facility Where Services Were Rendered</td>
<td>Required.</td>
</tr>
<tr>
<td>32*a.</td>
<td>Service Facility</td>
<td>Enter the Service Facility NPI# (non-shaded area)</td>
</tr>
<tr>
<td>32*b.</td>
<td>Service Facility</td>
<td>Enter the Service Facility NPI#</td>
</tr>
<tr>
<td>33.</td>
<td>Provider Name, Address and Phone</td>
<td>Enter name, address, and telephone number of provider rendering service. If a group is billing, enter group biller’s name, address and telephone number.</td>
</tr>
<tr>
<td>33*a.</td>
<td>Billing Provider NPI (non-shaded area)</td>
<td>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.</td>
</tr>
<tr>
<td>33*b.</td>
<td>Other ID</td>
<td>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.</td>
</tr>
</tbody>
</table>
### 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.

<table>
<thead>
<tr>
<th>Field Name/Status</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Type of Transaction</strong></td>
<td>Not required.</td>
</tr>
<tr>
<td>2. <strong>Predetermination/ Preauthorization Number</strong></td>
<td>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.”</td>
</tr>
<tr>
<td>3. <strong>Primary Payer Name and Address</strong></td>
<td>Required if applicable.</td>
</tr>
<tr>
<td>4. <strong>Other Dental or Medical Coverage</strong></td>
<td>Check appropriate box to indicate whether member has third party coverage</td>
</tr>
<tr>
<td>5. <strong>Subscriber name</strong></td>
<td>Required if applicable.</td>
</tr>
<tr>
<td>6. <strong>Date of Birth</strong></td>
<td>Required if applicable.</td>
</tr>
<tr>
<td>7. <strong>Gender</strong></td>
<td>Required if applicable.</td>
</tr>
<tr>
<td>8. <strong>Subscriber Identifier</strong></td>
<td>Required if applicable.</td>
</tr>
<tr>
<td>9. <strong>Plan/Group Number</strong></td>
<td>Required if applicable.</td>
</tr>
<tr>
<td>10. <strong>Relationship to Primary Subscriber</strong></td>
<td>Required if applicable.</td>
</tr>
<tr>
<td>11. <strong>Other Carrier Name, Address</strong></td>
<td>Required if applicable.</td>
</tr>
<tr>
<td>12. <strong>Primary Subscriber Name and Address</strong></td>
<td>Enter the member’s last name, first name and middle initial.</td>
</tr>
<tr>
<td>13. <strong>Date of Birth</strong></td>
<td>Enter member’s date of birth.</td>
</tr>
<tr>
<td>Field</td>
<td>Name/Status</td>
</tr>
<tr>
<td>---------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>14. Gender</td>
<td></td>
</tr>
<tr>
<td>15. Subscriber</td>
<td>Identifier</td>
</tr>
<tr>
<td>16. Plan/Group Number</td>
<td></td>
</tr>
<tr>
<td>17. Employer Name</td>
<td></td>
</tr>
<tr>
<td>18. Relationship to Primary Subscriber</td>
<td></td>
</tr>
<tr>
<td>19. Student Status</td>
<td></td>
</tr>
<tr>
<td>20. Name</td>
<td></td>
</tr>
<tr>
<td>21. Date of Birth</td>
<td></td>
</tr>
<tr>
<td>22. Gender</td>
<td></td>
</tr>
<tr>
<td>23. Patient ID/Account Number</td>
<td></td>
</tr>
<tr>
<td>24. Procedure date</td>
<td></td>
</tr>
<tr>
<td>27. Tooth Number (s) or Letter(s)</td>
<td></td>
</tr>
<tr>
<td>28. Tooth Surface</td>
<td></td>
</tr>
<tr>
<td>29. Procedure Code</td>
<td></td>
</tr>
<tr>
<td>Field</td>
<td>Name/Status</td>
</tr>
<tr>
<td>-------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>30.</td>
<td>Description</td>
</tr>
<tr>
<td>31.</td>
<td>Fee</td>
</tr>
<tr>
<td>32.</td>
<td>Other Fees</td>
</tr>
<tr>
<td>33.</td>
<td>Total Fee</td>
</tr>
<tr>
<td>34.</td>
<td>Missing Teeth</td>
</tr>
<tr>
<td>35.</td>
<td>Remarks</td>
</tr>
<tr>
<td>36.</td>
<td>Parent/Guardian Signature and Date</td>
</tr>
<tr>
<td>37.</td>
<td>Subscriber Signature And Date</td>
</tr>
<tr>
<td>38.</td>
<td>Place of Treatment</td>
</tr>
<tr>
<td>39.</td>
<td>Number of Enclosures</td>
</tr>
<tr>
<td>40.</td>
<td>Is Treatment for Orthodontics?</td>
</tr>
<tr>
<td>41.</td>
<td>Date Appliance Placed</td>
</tr>
<tr>
<td>42.</td>
<td>Months of Treatment</td>
</tr>
<tr>
<td>43.</td>
<td>Replacement of Prosthesis</td>
</tr>
<tr>
<td>44.</td>
<td>Date of Prior Placement</td>
</tr>
<tr>
<td>45.</td>
<td>Treatment Resulting</td>
</tr>
<tr>
<td>46.</td>
<td>Date of Accident</td>
</tr>
<tr>
<td>47.</td>
<td>Auto Accident State</td>
</tr>
<tr>
<td>Field</td>
<td>Name/Status</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
</tr>
<tr>
<td>48.</td>
<td>Billing Dentist/ Dental Entity Name And Address</td>
</tr>
<tr>
<td>49.</td>
<td>Provider ID (Group)</td>
</tr>
<tr>
<td>50.</td>
<td>License Number</td>
</tr>
<tr>
<td>51.</td>
<td>SSN or TIN</td>
</tr>
<tr>
<td>52.</td>
<td>Phone Number</td>
</tr>
<tr>
<td>53.</td>
<td>Signature of Treating Dentist</td>
</tr>
<tr>
<td>54.</td>
<td>Provider ID (Group)</td>
</tr>
<tr>
<td>55.</td>
<td>License Number</td>
</tr>
<tr>
<td>56.</td>
<td>Address (Treating Dentist)</td>
</tr>
<tr>
<td>57.</td>
<td>Phone Number (Treating Dentist)</td>
</tr>
<tr>
<td>58.</td>
<td>Treating Provider Specialty</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Field</th>
<th>Name/Status</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Group Number</td>
<td>Not required.</td>
<td></td>
</tr>
<tr>
<td>2. Card Holder ID</td>
<td>Enter nine-digit AHCCCS ID of recipient for whom the prescription was written.</td>
<td></td>
</tr>
<tr>
<td>3. Card Holder Name</td>
<td>Enter name of recipient for whom prescription was written.</td>
<td></td>
</tr>
<tr>
<td>4. Other Third Party Coverage</td>
<td>Check appropriate box to indicate whether recipient has third party coverage.</td>
<td></td>
</tr>
<tr>
<td>5. Patient Information</td>
<td>Enter recipient’s last name, first name, and middle initial; date of birth, if available; sex; and relationship to the cardholder.</td>
<td></td>
</tr>
<tr>
<td>6. Pharmacy Information</td>
<td>Enter name, street number, city, state and zip code of provider who filled prescription</td>
<td></td>
</tr>
<tr>
<td>7. Pharmacy Number</td>
<td>Enter six-digit AHCCCS provider ID number and two-digit locator code assigned.</td>
<td></td>
</tr>
<tr>
<td>8. Phone</td>
<td>Enter phone number, including area code, of pharmacy that filled prescription</td>
<td></td>
</tr>
<tr>
<td>9. Date Rx Was Written</td>
<td>Enter date of prescription as MM/DD/YY.</td>
<td></td>
</tr>
<tr>
<td>10. Date Rx Was Filled</td>
<td>Enter date of service for this billing. If prescription is a refill, date of refill should be entered.</td>
<td></td>
</tr>
<tr>
<td>11. Rx Number</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>12. New or Refill</td>
<td>Enter “N” if claim is new, “R” if it is a refill.</td>
<td></td>
</tr>
<tr>
<td>13. Metric Quantity</td>
<td>Enter quantity provided. If form is tablets or capsules, number should be number of pills dispensed.</td>
<td></td>
</tr>
<tr>
<td>Field</td>
<td>Name/Status</td>
<td>Instructions</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>14.</td>
<td>Days Supply</td>
<td>Enter number of days prescription is expected to cover.</td>
</tr>
<tr>
<td>15.</td>
<td>National Drug Code</td>
<td>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.</td>
</tr>
<tr>
<td>0000</td>
<td>1234</td>
<td>567</td>
</tr>
<tr>
<td>16.</td>
<td>Prescriber Indent.</td>
<td>Enter AHCCCS provider ID of the prescribing physician, if the number is available.</td>
</tr>
<tr>
<td>17.</td>
<td>DAW</td>
<td>Indicate whether prescribing provider required a brand name drug by entering “1”. If generic items were allowed, enter “0”.</td>
</tr>
<tr>
<td>18.</td>
<td>Ingredient Costs</td>
<td>Enter cost of ingredients of dispensed items to pharmacy.</td>
</tr>
<tr>
<td>19.</td>
<td>Dispensing Fee</td>
<td>Not required. Dispensing fee systematically added by DES/DDD system.</td>
</tr>
<tr>
<td>20.</td>
<td>Tax</td>
<td>Do not enter sales tax amounts. DES/DDD is exempt from payment of sales tax.</td>
</tr>
<tr>
<td>21.</td>
<td>Total Price</td>
<td>Enter sum of components’ cost (not including dispensing fee).</td>
</tr>
<tr>
<td>22.*</td>
<td>Deductible Amount</td>
<td>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.</td>
</tr>
<tr>
<td>23.</td>
<td>Balance</td>
<td>Enter amount due from DES/DDD (not including dispensing fee).</td>
</tr>
<tr>
<td>24.</td>
<td>Authorized Pharmacy</td>
<td>Authorized representative of pharmacy must sign and date claim. Rubber stamp signatures acceptable but must be initialed by a provider representative.</td>
</tr>
<tr>
<td></td>
<td>Representative</td>
<td></td>
</tr>
</tbody>
</table>
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:
DESD/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
specialty physician also does not require prior authorization. However, for any providers, including specialty providers, to receive reimbursement for billing codes other than CPT Evaluation and Management, prior authorization must be obtained from the Health Care Services Prior Authorization Unit. The following inpatient and ancillary services also require PA:

- Physician treatment
- Medical laboratory tests paid at more than $1,000 according to the CFFS.
- X-ray and other diagnostic imaging procedures paid at more than $1,000 according to the CFFS.
- Hospitalization
- Durable medical equipment paid at more than $100 according to the CFFS.
- Outpatient surgery
- Medical supplies paid at more than $100 according to the CFFS.
- Emergency dental services for members aged 21 years and older
- Medically necessary transportation for covered medical services
- Orthotics and Prosthetics over $100 per item

Check the list of Covered Services in this Manual for more specifics.

Prior authorization can be obtained by calling:

(602)238-9028  Monday through Friday (excluding holidays)
between 8:00 am and 5:00 pm

or

1-800-624-4964  24 hours per days / 7 days per week.

Prior authorization may also be faxed to:

1-602-253-9083  Faxed requests for PA will be responded to within 2 working days of receipt. (See Appendix C: PA Fax Form)

Prior authorization for the services listed above can also be obtained through the US mail by sending a completed PA Fax Form requesting covered services to:

Prior Authorization Unit
DES/Division of Developmental Disabilities
2200 N. Central Avenue, Suite 506
Phoenix, Arizona 85004

Regardless of the transmittal mode of the PA request, the PA nurse may request additional information to document the medical necessity of the request. The PA nurse may call, fax, or write to the provider to request needed information.
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.


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 as 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.
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 proving 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 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:

<table>
<thead>
<tr>
<th>Category</th>
<th>Recommendation for Next Dental Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergent</td>
<td>Within 24 hours of request</td>
</tr>
<tr>
<td>Urgent</td>
<td>Within 3 days of request</td>
</tr>
<tr>
<td>Routine</td>
<td>within 45 days of request</td>
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</tbody>
</table>

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:

- Bone marrow biopsy with needle or trocar
- Bone marrow aspiration
- Intravenous chemotherapy administration, push technique
- Chemotherapy administration into central nervous system by spinal puncture
- Diagnostic lumbar spinal puncture, and
- 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:

<table>
<thead>
<tr>
<th>Patient Status</th>
<th>ICD-9 Diagnosis Code</th>
<th>CPT-4 Procedure Code</th>
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</thead>
<tbody>
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<td>New Patient EPSDT</td>
<td>V20.2</td>
<td>99381</td>
</tr>
<tr>
<td>Established Pt.</td>
<td>V20.2</td>
<td>99392</td>
</tr>
<tr>
<td>with Immunization</td>
<td>V20.2</td>
<td>90707</td>
</tr>
</tbody>
</table>
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 AHDS 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-caries 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
APPENDIX B:

DISTRICT NURSE CONTACTS
<table>
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<th>PHONE AND ADDRESS</th>
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<td>BOX 13178</td>
<td>275-F</td>
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<td>ANN LYNCH</td>
<td>BOX 13178</td>
<td>275-F</td>
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<tr>
<td>ANNETTE LAMMON-BELCHER</td>
<td>BOX 13178</td>
<td>275-F</td>
<td>520-519-1733</td>
<td></td>
<td><a href="mailto:ABelcher@azdes.gov">ABelcher@azdes.gov</a></td>
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<tr>
<td>ANICK RAPPOLE</td>
<td>BOX 13178</td>
<td>275-F</td>
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<td></td>
<td><a href="mailto:ARappole@azdes.gov">ARappole@azdes.gov</a></td>
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<td>BERNICE BAUM</td>
<td>ATPT BOX 13178</td>
<td>275-F</td>
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<td>CANDY LIVINGSTON</td>
<td>BOX 13178</td>
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<td>CHERYL MENDOZA</td>
<td>910 N BROAD STREET</td>
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<td>CONNIE ALEXANDER</td>
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<td>CONNIE THOMPSON</td>
<td>2200 N CENTRAL, SUITE 207</td>
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<tr>
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<tr>
<td>DONNA POOL</td>
<td>519 E BEALE STREET, SUITE 155</td>
<td>402-F</td>
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<td><a href="mailto:DPool@azdes.gov">DPool@azdes.gov</a></td>
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<tr>
<td>GLORIA SULLIVAN</td>
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<td><a href="mailto:GSullivan@azdes.gov">GSullivan@azdes.gov</a></td>
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<tr>
<td>JACKIE NISCHAN</td>
<td>2200 N CENTRAL, SUITE 207</td>
<td>795-M</td>
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<td><a href="mailto:Jnischan@azdes.gov">Jnischan@azdes.gov</a></td>
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<tr>
<td>JENIFER BRITTON</td>
<td>232 LONDON BRIDGE ROAD</td>
<td>421-F</td>
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<td><a href="mailto:JBritton@azdes.gov">JBritton@azdes.gov</a></td>
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<tr>
<td>JUDY WACHSMAN</td>
<td>2200 N CENTRAL, SUITE 207</td>
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<td>KATY KAREZ</td>
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<td>LAURA McKay</td>
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**DDD DRR11.xls - Shared** 3/5/08
APPENDIX C:

PRIOR AUTHORIZATION (PA) FORMS
### I.H.S. DIAPER/BRIEF ORDER FORM

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

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<td>PAMPERS, #2 (12-18 lbs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAMPERS, #3 (16-28lbs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAMPERS, #4 (22-37lbs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAMPERS, #5 (27+ lbs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAMPERS, #6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PULL-UPS GN, S/M BOYS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PULL-UPS GN, S/M GIRLS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PULL-UPS GN, Lg/XL BOYS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PULL-UPS GN, Lg/XL GIRLS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PULL-UPS ALL NIGHT MED.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PULL-UPS ALL NIGHT Lg/XL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PULL-UP PROTECTION +, SMALL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PULL-UP PROTECTION +, MED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PULL-UP PROTECTION +</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TAB TYPE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BRIEFS, YOUTH FULL FIT (15-22in)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BRIEFS, SMALL STAY DRY (20-31in)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BRIEFS, SMALL MOLICARE (20-30in)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BRIEFS, MED NU-FIT (32-44in)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BRIEFS, MED, MOLICARE (27-50in)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BRIEFS, LARGE, NU-FIT (45-58in)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BRIEFS, LARGE MOLICARE (43-64in)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BRIEFS, X-LARGE NU-FIT (45-58in)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1/18/08 JG
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 # [ ] 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. 85008-6123

2/08jg
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 SHIPING. INCORRECT DIAPER SIZES CANNOT BE RETURNED, NOR CAN
THEY BE REPLACED WITH A NEW SIZE UNTIL THE NEXT SHIPMENT DUE DATE.**

1/18/08 jg
# AUTHORIZATION REQUEST

## FOR

## INCONTINENCE BRIEFS

### DDD/LTC I.H.S

## MEMBER INFORMATION

<table>
<thead>
<tr>
<th>Name:</th>
<th>DOB:</th>
<th>AHCCCS ID#:</th>
</tr>
</thead>
</table>

Other Insurance: [ ] Medicare  [ ] 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.

<table>
<thead>
<tr>
<th>PCP Signature</th>
<th>PCP Name (Printed)</th>
<th>Date</th>
</tr>
</thead>
</table>

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/Description 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
Attention: DDD Claims
Phoenix AZ, 85005-6123

1/18/08 jg
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 complete 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
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 ___________ ICD9-CODE ___________

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 SIGNATURE ___________ DATE __/__/__ TIME ______

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

Revised 01/18/08 JG
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 DOD 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

PATIENT AHCCCS ID #_____________  DOB______________  ( ) TRAUMA ( ) INDUSTRIAL

PROVIDER NAME:______________________  PROVIDER AHCCCS ID #______________________

PROVIDER ADDRESS:____________________________________

REFERRING DOCTOR____________________________________  PHONE #______________________

DIAGNOSIS DESCRIPTION______________________  ICD-9 CODE______________________

MEDICAL NECESSITY FOR VISIT____________________________________

BILLING MODIFIER 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 ______

Revised 01/18/08 jg
TO PROCESS AUTHORIZATION THE FOLLOWING 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 _________________________

AUTHORIZATION #_________________________ 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

Revised 1/18/08jg
APPENDIX D:

PREHOSPITAL MEDICAL CARE DIRECTIVE
(ADVANCE DIRECTIVE)

SAMPLE FORM
PREHOSPITAL MEDICAL CARE DIRECTIVE

SIDE ONE

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

Patient: ___________________________ Date: ___________________________

[Patient's signature or mark]

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): ___________________________

Name and telephone number of patient's physician: ___________________________

both sides must be completed! 
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

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

Witness

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. Standers, 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
# CRS Application 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** (602) 406-5731 or Fax-(602) 406-7166
- **2600 N. Wyatt Dr., Tucson, AZ 85712** (800) 231-8291 Tel-(520) 324-5437 or Fax-(520) 324-3233
- **120 N. Beaver, Flagstaff, AZ 86001** (800) 232-1018 Tel-(928) 773-2054 or Fax-(928) 773-2266
- **2400 Avenue A, Yuma, AZ 85364** (800) 837-7309 Tel-(928) 336-7095 or Fax-(928) 336-7497

<table>
<thead>
<tr>
<th>CRS APPLICATION FORM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TO DAY'S DATE:</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>CHILD'S NAME</strong> (Last, First, Middle)</th>
</tr>
</thead>
</table>

**SEX**

<table>
<thead>
<tr>
<th><strong>M</strong></th>
<th><strong>F</strong></th>
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</table>

**DATE OF BIRTH** (mo/day/yr)

<table>
<thead>
<tr>
<th><strong>RELATIONSHIP TO CHILD</strong></th>
</tr>
</thead>
</table>

- Natural Parent(s)
- Adoptive
- Foster
- Other

<table>
<thead>
<tr>
<th><strong>PARENT OR GUARDIAN</strong> (Last Name, First Name)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>RACE</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>DATE</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>CHILD'S ADDRESS</strong></th>
<th><strong>STREET</strong></th>
<th><strong>CITY</strong></th>
<th><strong>STATE</strong></th>
<th><strong>ZIP CODE</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>COUNTY</strong></th>
<th><strong>US Citizen</strong></th>
</tr>
</thead>
</table>

- Yes
- No

<table>
<thead>
<tr>
<th><strong>HOME TELEPHONE -( )-</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>MESSAGE/CELL PHONE NUMBER -( )-</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>WORK PHONE NUMBER -( )-</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>E-MAIL ADDRESS</strong></th>
</tr>
</thead>
</table>

**IN EMERGENCY NOTIFY** (Name, Relationship, Address, Telephone)

<table>
<thead>
<tr>
<th><strong>CHILD'S Primary Care Practitioner</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>ADDRESS</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>PHONE NUMBER</strong></th>
</tr>
</thead>
</table>

**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:**

<table>
<thead>
<tr>
<th><strong>LIST PRIMARY DIAGNOSES</strong> (e.g., Cleft Lip, VSD, Cerebral Palsy, etc.) IF AVAILABLE, <strong>PLEASE SEND RECORDS WITH THIS FORM.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
</tr>
<tr>
<td>2)</td>
</tr>
<tr>
<td>3)</td>
</tr>
<tr>
<td>4)</td>
</tr>
<tr>
<td>5)</td>
</tr>
</tbody>
</table>

**LIST ANY KNOWN ALLERGIES**

1)  
2)  
3)  
4)  
5)  

**HAS CHILD RECEIVED CRS SERVICES BEFORE?:**

- **YES**
- **NO**

<table>
<thead>
<tr>
<th><strong>YEAR?</strong></th>
<th><strong>WHERE?</strong></th>
<th><strong>PRIMARY LANGUAGE?</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>NAME OF PERSON WHO COMPLETED THIS FORM</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>ADDRESS</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>PHONE</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>RELATIONSHIP TO PATIENT</strong></th>
</tr>
</thead>
</table>

**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.

<table>
<thead>
<tr>
<th><strong>Signature of Consenting Party</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Date</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Relationship to Patient</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>AHCCCS PLAN</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>YES</strong></td>
</tr>
<tr>
<td><strong>NO</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>HEALTH INSURANCE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>YES</strong></td>
</tr>
<tr>
<td><strong>NO</strong></td>
</tr>
</tbody>
</table>

Please include copy of insurance information or card.

**FOR CRS CLINIC USE ONLY**

<table>
<thead>
<tr>
<th><strong>APPLICATION REVIEWED BY:</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>DATE</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Approved</strong></th>
</tr>
</thead>
</table>

**SPECIALTY CLINIC ASSIGNMENTS:**

- **PEND-diagnostic tests**
- **PEND- waiting for medical documentation**
- **DENY-no medical documentation**
- **DENY-not medically eligible**
- **DENY - Other reason**

Rev. CRS Referral Form 07/05/07
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

<table>
<thead>
<tr>
<th>AGE</th>
<th>PROCEDURES</th>
<th>INFANCY</th>
<th>EARLY CHILDHOOD</th>
<th>MIDDLE CHILDHOOD</th>
<th>ADOLESCENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>new born</td>
<td>2-4 days</td>
<td>by 1 mo</td>
<td>2 mo</td>
</tr>
<tr>
<td></td>
<td>History Initial/Interval</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Height &amp; Weight, including Body Mass Index (BMI) for those 24 months and older</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Head Circumference</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Blood Pressure – PCP should assess the need for B/P measurement for children birth to 24 months</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>Nutritional Assessment</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Vision</td>
<td>SEE SEPARATE SCHEDULE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hearing/Speech</td>
<td>SEE SEPARATE SCHEDULE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dev./Behavioral Assess.</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Physical Examination</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Immunization</td>
<td>SEE SEPARATE SCHEDULE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tuberculin Test</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>Hematocrit/Hemoglobin</td>
<td>x</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>Urinalysis</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Lead Screen /Verbal</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Lead Screen/Blood Test</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Anticipatory Guidance</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Dyslipidemia Screening</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Dyslipidemia Testing</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Dislipidemia Testing</td>
<td>x (one time testing between 18 and 20 years of age)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>STI Screening</td>
<td>x (risk assessment for those 11-20)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cervical Dysplasia Screening</td>
<td>x (risk assessment for those 11-20)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dental Referral</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
</tbody>
</table>

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  
- **x** = 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.

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

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Months of Age</th>
<th>Years of Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision +</td>
<td>New born</td>
<td>3*</td>
</tr>
<tr>
<td></td>
<td>2 - 4 Days</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>by 1 mo</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>11</td>
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<tr>
<td></td>
<td>12</td>
<td>12</td>
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<tr>
<td></td>
<td>15</td>
<td>13</td>
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<tr>
<td></td>
<td>18</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>24</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>3*</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>19 through 20</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>years of age</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11</td>
<td></td>
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<td></td>
<td>12</td>
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<td>13</td>
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<td>14</td>
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<td>16</td>
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<td>17</td>
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<td></td>
<td>18</td>
<td></td>
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<tr>
<td></td>
<td>19 through</td>
<td></td>
</tr>
<tr>
<td></td>
<td>20 years of</td>
<td></td>
</tr>
<tr>
<td></td>
<td>age</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Months of Age</th>
<th>Years of Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing/</td>
<td>New born</td>
<td>3</td>
</tr>
<tr>
<td>Speech+</td>
<td>2 - 4 days</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>2 weeks</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>By 1 mo</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>6 weeks</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>13</td>
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<td></td>
<td>12</td>
<td>14</td>
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<tr>
<td></td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>18</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>24</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Through 20</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>years of age</td>
<td>19 through 20</td>
</tr>
<tr>
<td></td>
<td>age</td>
<td></td>
</tr>
</tbody>
</table>

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
## 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.

<table>
<thead>
<tr>
<th>AGE</th>
<th>12-24 months</th>
<th>2-6 years</th>
<th>6-12 years</th>
<th>12 years and older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical oral examination including but not limited to the following:</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Assess oral growth and development</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Caries-risk Assessment</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Assessment for need for fluoride supplementation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Anticipatory Guidance/Counseling</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Oral hygiene counseling</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Dietary counseling</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Injury prevention counseling</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Counseling for nonnutritive habits</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Substance abuse counseling</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Counseling for intraoral/perioral piercing</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Assessment for pit and fissure sealants</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Radiographic Assessment</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Prophylaxis and topical fluoride</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

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

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](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](http://www.vaers.hhs.gov) or by telephone, 800-822-7967.

<table>
<thead>
<tr>
<th>Vaccine ▼</th>
<th>Age ▶</th>
<th>Birth</th>
<th>1 month</th>
<th>2 months</th>
<th>4 months</th>
<th>6 months</th>
<th>12 months</th>
<th>15 months</th>
<th>18 months</th>
<th>19–23 years</th>
<th>2–3 years</th>
<th>4–6 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B&lt;sup&gt;1&lt;/sup&gt;</td>
<td>HepB</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HepB</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rotavirus&lt;sup&gt;2&lt;/sup&gt;</td>
<td>RV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphtheria, Tetanus, Pertussis&lt;sup&gt;3&lt;/sup&gt;</td>
<td>DTaP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DTaP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemophilus influenzae type b&lt;sup&gt;4&lt;/sup&gt;</td>
<td>Hib</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Hib</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal&lt;sup&gt;5&lt;/sup&gt;</td>
<td>PCV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PCV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inactivated Poliovirus</td>
<td>IPV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>IPV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza&lt;sup&gt;6&lt;/sup&gt;</td>
<td>MMR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MMR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, Mumps, Rubella&lt;sup&gt;7&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Varicella</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella&lt;sup&gt;8&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A&lt;sup&gt;9&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal&lt;sup&gt;10&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### 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<sup>®</sup> 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<sup>®</sup> or Comvax<sup>®</sup> [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
- TrHiB<sup>®</sup> (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 2005;54[No. RR-77].

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

- Administer MVC 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-77].
- Persons who received MPSV 3 or more years previously and who remain at increased risk for meningococcal disease should be revaccinated with MVC.
### Vaccine ▼ Age ▶

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>7−10 years</th>
<th>11−12 years</th>
<th>13−18 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus, Diphtheria, Pertussis&lt;sup&gt;1&lt;/sup&gt;</td>
<td>see footnote 1</td>
<td>Tdap</td>
<td>Tdap</td>
</tr>
<tr>
<td>Human Papillomavirus&lt;sup&gt;2&lt;/sup&gt;</td>
<td>see footnote 2</td>
<td>HPV (3 doses)</td>
<td>HPV Series</td>
</tr>
<tr>
<td>Meningococcal&lt;sup&gt;3&lt;/sup&gt;</td>
<td>MCV</td>
<td>MCV</td>
<td>MCV</td>
</tr>
<tr>
<td>Influenza&lt;sup&gt;4&lt;/sup&gt;</td>
<td>Influenza (Yearly)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal&lt;sup&gt;5&lt;/sup&gt;</td>
<td>PPSV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A&lt;sup&gt;6&lt;/sup&gt;</td>
<td>HepA Series</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B&lt;sup&gt;7&lt;/sup&gt;</td>
<td>HepB Series</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inactivated Poliovirus&lt;sup&gt;8&lt;/sup&gt;</td>
<td>IPV Series</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, Mumps, Rubella&lt;sup&gt;9&lt;/sup&gt;</td>
<td>MMR Series</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella&lt;sup&gt;10&lt;/sup&gt;</td>
<td>Varicella Series</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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](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](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.
   - For 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-6]), 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 since doses. Use the second appropriate for the child’s age.

**CATCH-UP SCHEDULE FOR PERSONS AGED 4 MONTHS THROUGH 6 YEARS**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age for Dose 1</th>
<th>Dose 1 to Dose 2</th>
<th>Minimum Interval Between Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hepatitis B</strong></td>
<td>Birth</td>
<td>4 weeks</td>
<td>8 weeks (and at least 16 weeks after first dose)</td>
</tr>
<tr>
<td><strong>Rotavirus</strong></td>
<td>6 wks</td>
<td>4 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td><strong>Diphtheria, Tetanus, Pertussis</strong></td>
<td>6 wks</td>
<td>4 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td><strong>Haemophilus influenzae type b</strong></td>
<td>6 wks</td>
<td>8 weeks (as final dose)</td>
<td>4 weeks</td>
</tr>
<tr>
<td><strong>Pneumococcal</strong></td>
<td>6 wks</td>
<td>4 weeks</td>
<td>8 weeks (as final dose)</td>
</tr>
<tr>
<td><strong>Inactivated Poliovirus</strong></td>
<td>12 wks</td>
<td>3 months</td>
<td>4 weeks</td>
</tr>
<tr>
<td><strong>Measles, Mumps, Rubella</strong></td>
<td>12 mos</td>
<td>4 weeks</td>
<td>8 weeks</td>
</tr>
<tr>
<td><strong>Varicella</strong></td>
<td>12 mos</td>
<td>6 months</td>
<td>6 months</td>
</tr>
</tbody>
</table>

*Catch-up schedule includes precautions and contraindications for immunization, is available from the National Center for Immunization and Respiratory Diseases at http://www.cdc.gov/vaccines or telephone, 800-CDC-INFO (800-232-4636) or 800-822-7967.*

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. Retavirus 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 older or older). Administer the final dose in the series by age 8 months 0 days.

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 yr 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 (final) dose should be administered 1 month after age 12 months and at least 4 weeks after the second dose.
   - If the first 2 doses were administered at age 12 months or older, 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 2 doses were administered 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.

Information about reporting reactions after immunization is available online at http://www.cdc.gov/vaccines or by telephone, 800-822-7967. Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for immunization, is available from the National Center for Immunization and Respiratory Diseases at http://www.cdc.gov/vaccines or telephone, 800-CDC-INFO (800-232-4636).

**CATCH-UP SCHEDULE FOR PERSONS AGED 7 THROUGH 18 YEARS**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age</th>
<th>Dose 1 to Dose 2</th>
<th>Minimum Interval Between Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tetanus, Diphtheria, Pertussis</strong></td>
<td>7 yrs</td>
<td>4 weeks</td>
<td>6 months</td>
</tr>
<tr>
<td><strong>Human Papillomavirus</strong></td>
<td>9 yrs</td>
<td>4 weeks</td>
<td>6 months</td>
</tr>
<tr>
<td><strong>Hepatitis A</strong></td>
<td>12 mos</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td><strong>Hepatitis B</strong></td>
<td>Birth</td>
<td>4 weeks</td>
<td>8 weeks (and at least 16 weeks after first dose)</td>
</tr>
<tr>
<td><strong>Inactivated Poliovirus</strong></td>
<td>6 wks</td>
<td>4 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td><strong>Measles, Mumps, Rubella</strong></td>
<td>12 mos</td>
<td>4 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td><strong>Varicella</strong></td>
<td>12 mos</td>
<td>4 weeks</td>
<td>4 weeks</td>
</tr>
</tbody>
</table>

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, 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 acellular pertussis vaccine (Tdap).**
    - Doses of Td and Tdap 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 1 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](http://www.ahcccs.state.az.us).

Revised: 11/01/2007, 01/01/2004, 11/01/2003, 06/01/2003  
Effective: 07/01/2001
### AHCCCS EPSDT Tracking Form

**2 through 4 Days Old**

<table>
<thead>
<tr>
<th>Date</th>
<th>Last Name</th>
<th>First Name</th>
<th>AHCCCS ID #</th>
<th>DOB</th>
<th>Age</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Primary Care Provider</th>
<th>PCP ph. #</th>
<th>Health Plan</th>
<th>Accompanied by (name)</th>
<th>Relationship</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NICU:</th>
<th>PEIDS:</th>
<th>PEIDS Pathway:</th>
<th>Allergies:</th>
<th>Temp:</th>
<th>Pulse:</th>
<th>Resp:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ yes</td>
<td>☐ no</td>
<td>☐ yes</td>
<td>☐ no</td>
<td>☐ yes</td>
<td>☐ no</td>
<td>☐ yes</td>
</tr>
</tbody>
</table>

#### Medications:

<table>
<thead>
<tr>
<th>Birth wt:</th>
<th>Wt:</th>
<th>%</th>
<th>Length:</th>
<th>%</th>
<th>Head circ:</th>
<th>%</th>
</tr>
</thead>
</table>

#### 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 baby?  
- Do you feel safe in your home?

---

#### NUTRITIONAL SCREEN:

- ☐ Breast feeding  
- ☐ Formula:  
- ☐ Adequate intake  
- ☐ Supplements:

#### DEVELOPMENTAL SCREEN:

- ☐ Rooting reflex  
- ☐ Startle  
- ☐ Suck & swallow  
- ☐ Other

#### AGE APPROPRIATE EDUCATION AND GUIDANCE:

- ☐ Supine sleep  
- ☐ Car seat/rear facing  
- ☐ Infant bonding  
- ☐ Bottle prop  
- ☐ Passive smoke  
- ☐ Support/who can help?  
- ☐ Infant crying/what to do?  
- ☐ Safe bathing/water temperature  
- ☐ Shaken baby prevention  
- ☐ Guns  
- ☐ Other

#### BEHAVIORAL HEALTH SCREEN:

- ☐ Family Adjustment/parent responds positively to child  
- ☐ Length of time infant cries  
- ☐ Encourage holding  
- ☐ Infant hands to mouth/self calming  
- ☐ Other

---

#### COMPREHENSIVE PHYSICAL EXAM:

<table>
<thead>
<tr>
<th>Skin/Hair/Nails</th>
<th>Lungs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes/Vision</td>
<td>Abdomen</td>
</tr>
<tr>
<td>Ear</td>
<td>Genitourinary</td>
</tr>
<tr>
<td>Mouth/Throat/Teeth</td>
<td>Extremities</td>
</tr>
<tr>
<td>Nose/Head/Neck</td>
<td>Spine</td>
</tr>
<tr>
<td>Heart</td>
<td>Neurological</td>
</tr>
</tbody>
</table>

---

#### 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 ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason

- ☐ Indicates referred ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Speech ☐ AzEIP/ DDD ☐ Developmental  
  - ☐ Behavioral ☐ Specialty ☐ Early Head Start ☐ 2nd Newborn hearing screening (if needed) ☐ Other

---

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

---

Revised November 1, 2007
### 1 Month Old

**AHCCCS EPSDT Tracking Form**

<table>
<thead>
<tr>
<th>Date</th>
<th>Last Name</th>
<th>First Name</th>
<th>AHCCCS ID #</th>
<th>DOB</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Care Provider</th>
<th>PCP ph.</th>
<th>Health Plan</th>
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<th>Wt:</th>
<th>%</th>
<th>Length:</th>
<th>%</th>
<th>Head circ:</th>
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**Hospital Newborn Hearing Screen:**  □ ABR  □ OAE  □ Lt. ear  □ refer  □ Unknown  
**Second Newborn Hearing Screen (if 2nd needed/completed):**  □ ABR  □ OAE  □ Lt. ear  □ refer  □ Unknown

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

---

**NUTRITIONAL SCREEN:**  □ Breast fed  □ Formula: ____________  
□ Cereal  □ Adequate intake  □ Supplements: ____________

**DEVELOPMENTAL SCREEN:**  □ 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:**  □ 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:**  □ Family Adjustment/parent responds positively to child  □ Length of time infant cries  □ Infant hands to mouth/self calming  □ Encourage holding  □ Other

**COMPREHENSIVE PHYSICAL EXAM:**

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**ASSESSMENT/PLAN/FOLLOW UP**

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□ 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

See Additional Supervisory note  □ Yes  □ No

**Date/Time**  
**Clinician name (print)**  
**Clinician Signature**

Revised November 1, 2007
<table>
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<th>Length:</th>
<th>%</th>
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**Risk indicators of hearing loss:** ☐ yes ☐ no

**Hospital Newborn Hearing Screen:** □ ABG □ OAE: Rt. ear ☐ pass ☐ refer □ Lt. ear ☐ pass ☐ refer ☐ Unknown

**Second Newborn Hearing Screen (if 2nd needed/completed):** □ ABG □ 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:

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### ASSESSMENT/PLAN/FOLLOW UP

**LABS ORDERED:** ☑ indicates ordered: ☐ 2nd Newborn screening (if needed) ☐ Other

**IMMUNIZATIONS:** ☑ indicates ordered: □ Pt. Needs immunization today  ☐ Delayed/Deferred  □ Parent refuses  ☐ Other reason  □ Hepatitis B  □ DTaP  □ Hib  □ IPV  □ PCV  □ Rotavirus  □ Other

**REFERRALS:** ☑ indicates referred: □ CRS □ WIC □ ALTCS □ PT □ OT □ Speech □ AzEIP/DDD □ Developmental □ Behavioral □ Early Head Start □ Specialty □ Other

---

Date/Time  Clinician name (print)  Clinician Signature  Revised November 1, 2007

See Additional Supervisory note  ☑ Yes  ☐ No
4 Months Old

Date | Last Name | First Name | AHCCCS ID # | DOB | Age
--- | --- | --- | --- | --- | ---

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

NICU: | PEDS: | PEDS Pathway: | Birth Wt: | Allergies: | Temp: | Pulse: | Resp:
- [ ] yes | - [ ] yes | - [ ] no | - [ ] yes | - [ ] no | - | - | -

Risk indicators of hearing loss: | Medications: | Wt: | % | Length: | % | Head circ: | %
- [ ] yes | - [ ] no | - | - | - | - | - | -

**PARENTAL CONCERNS/HISTORY:**

**NUTRITIONAL SCREEN:** [X] indicates guidance given:
- [ ] Breast fed | [ ] Formula: ____________________________________________
- [ ] Cereal | [ ] Plan to introduce solids ________________________________
- [ ] Soda/Juice | [ ] Adequate intake | [ ] Supplements:

**DEVELOPMENTAL SCREEN:** [X] 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:** [X] 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 temperment/easy/sensitive | [ ] Passive smoke | [ ] Parent reads to child | [ ] Other

**BEHAVIORAL HEALTH SCREEN:** [X] 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:**

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**ASSESSMENT/PLAN/FOLLOW UP**

[ ] indicates ordered

[ ] indicates ordered

[ ] Pt. Needs immunization today | [ ] Delayed/Deferred | [ ] Parent refuses | [ ] Other reason
| [ ] Hepatitis B | [ ] DTP | [ ] Hib | [ ] IPV | [ ] PCV | [ ] Rotavirus | [ ] Other

[ ] indicates referred

[ ] CRS | [ ] WIC | [ ] ALTCS | [ ] PT | [ ] OT | [ ] Audiology | [ ] Speech | [ ] AzEIP/ DDD
| [ ] Developmental | [ ] Early Head Start | [ ] Behavioral | [ ] Specialty | [ ] Other

See Additional Supervisory

Date/Time | Clinician name (print) | Clinician Signature | note | [ ] Yes | [ ] No
--- | --- | --- | --- | --- | ---
Revised November 1, 2007
### 6 Months Old

**AHCCCS EPSDT Tracking Form**

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<thead>
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<th>Medications:</th>
<th>Wt: %</th>
<th>Length: %</th>
<th>Head circ: %</th>
</tr>
</thead>
</table>

**Parental Concerns/History:**

**Verbal Lead Risk Assessment:**
- At risk □ yes □ no (if yes, a blood lead test is required)

**Nutritional Screen:**
- Adequate intake □
- Breast fed □
- Formula: ____________
- Rice cereal □
- Solids □
- Soda/Juice □
- Supplements: ____________

**Developmental Screen:**
- “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:**
- 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:**
- 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:**

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**Assessment/Plan/Follow Up**

- □ Indicates ordered
- □ Indicates referred

**Date/Time:**

Clinician name (print) ____________

Clinician Signature ____________

Note □ Yes □ No

Revised November 1, 2007

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See Additional Supervisory
9 Months Old

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**PARENTAL CONCERNS/HISTORY:**

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

**ORAL SCREENING:** [X] INDICATES GUIDANCE GIVEN: [ ] Brushing teeth [ ] White spots on teeth

**NUTRITIONAL SCREEN:** [X] INDICATES GUIDANCE GIVEN: [ ] Adequate intake [ ] Breast fed [ ] Formula: [ ]

<table>
<thead>
<tr>
<th>Soda/ Juice</th>
<th>Solids</th>
<th>Supplements:</th>
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**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:** [X] INDICATES GUIDANCE GIVEN: [ ] Drowning prevention [ ] Emergency 911

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<th>Sun Safety</th>
<th>Baby proofing</th>
<th>Car seat/rear facing</th>
<th>Sleep/wake cycle</th>
<th>Wary of strangers</th>
<th>Introduce board books</th>
<th>Soft texture finger foods/choking</th>
<th>Redirection/positive parenting</th>
<th>Exploration/learning</th>
<th>Passive smoke</th>
<th>Language/read to child</th>
<th>Follow child’s lead in play</th>
<th>Parent communicates to child “what things are” (ball, cat etc)</th>
<th>[ ] Other</th>
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**BEHAVIORAL HEALTH SCREEN:** [X] 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:**

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**ASSESSMENT/PLAN/FOLLOW UP**

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<th>[X] INDICATES ORDERED</th>
<th>[ ] Hgb/Hct (perform at 9 months)</th>
<th>[ ] Other</th>
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<tr>
<td>[X] INDICATES ORDERED</td>
<td>[ ] Pt. Needs immunization today</td>
<td>[ ] Delayed/Deferred</td>
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<td>reason</td>
<td>[ ] Hepatitis B</td>
<td>[ ] DTap</td>
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**Date/Time**

**Clinician name (print)**

**Clinician Signature**

**See Additional Supervisory note** [ ] Yes [ ] No

Revised November 1, 2007
**12 Months Old**  
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Relationship

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**Risk indicators of hearing loss:**  
yes | no

**Medications:**  
Wt: %  
Length: %  
Head circ: %

**PARENTAL CONCERNS/HISTORY:**

### DENTAL SCREEN
- Daily tooth brushing  
- First dental appointment  
- White spots on teeth  

**NUTRITIONAL SCREEN**
- Breast fed  
- Formula:

- Adequate intake
- Solids:
- Supplements:
- Soda
- Juice

### DEVELOPMENTAL SCREEN
- First steps
- “Mama” “dada” specific
- Uses single words
- 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
- 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
- Family adjustment/parent responds positively to child
- Self calming
- Prefers primary care giver over all others
- Shy/anxious with strangers

### COMPREHENSIVE PHYSICAL EXAM

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<td>Spine (scoliosis)</td>
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### ASSESSMENT/PLAN/FOLLOW UP

**LABS ORDERED**
- Blood Lead Test (perform at 12 months)
- TB skin test (if at risk)

**IMMUNIZATIONS**
- Pt. Needs immunization today
- Delayed/Deferred
- Parent refuses
- Other reason
- Had chicken pox
- Hep A
- Hep B
- MMR
- Varicella
- DtaP
- Hib
- IPV
- PCV
- Influenza

**REFERRALS**
- CRS
- WIC
- ALTCS
- PT
- OT
- Audiology
- Speech
- AzEIP/DDD
- Developmental
- Behavioral
- Early Head Start
- Dental
- Specialty
- Other

---

Date/Time  
Clinician name (print)  
Clinician Signature  
note Yes No  
Revised November 1, 2007

See Additional Supervisory Note
<table>
<thead>
<tr>
<th>Date</th>
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</table>

**NICU:** □ yes □ no  
**PEDS:** □ yes □ no  
**PEDS Pathway:**  
**Birth Wt:**  

**Allergies:**  

**Temp:**  
**Pulse:**  
**Resp:**  

**Risk indicators of hearing loss:** □ yes □ no  
**Medications:**  
**Wt:** %  
**Length:** %  
**Head circ:** %  

**PARENTAL CONCERNS/HISTORY:**  

**VERBAL LEAD RISK ASSESSMENT:** □ yes □ no  (if yes a blood lead test is required)  

**DENTAL SCREENING:** □ Brushing daily □ 1st Dental appointment □ White spots on teeth  

**NUTRITIONAL SCREEN:** □ Feeds self □ Breast fed/whole milk □ Nutritionally balanced diet □ Junk food □ Soda/Juice □ Over weight □ Activity □ Supplements  

**DEVELOPMENTAL SCREEN:** □ 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:** □ Drowning prevention □ Emergency 911 □ Sun safety □ Car seat safety/40/4/4 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:** □ 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:**  

<table>
<thead>
<tr>
<th>Skin/Hair/Nails</th>
<th>Lungs</th>
<th>Eyes/Vision</th>
<th>Abdomen</th>
<th>Ear</th>
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<th>Spine</th>
<th>Heart</th>
<th>Neurological</th>
</tr>
</thead>
</table>

**ASSESSMENT/PLAN/FOLLOW UP**  

**LABS ORDERED:** □ TB skin test (if at risk)  

**IMMUNIZATIONS:** □ Pt. Needs immunization today □ Delayed/Deferred □ Parent refuses □ Other reason □ History of chicken pox □ HepA □ HepB □ MMR □ Varicella □ DTaP □ Hib □ IPV □ PCV □ Influenza □ Other  

**REFERRALS:** □ CRS □ WIC □ ALTCS □ PT □ OT □ Audiology □ Speech □ AzEIP/DDD □ Developmental □ Behavioral □ Dental □ Early Head Start □ Specialty □ Other  

See Additional Supervisory note  □ Yes □ No  

Revised November 1, 2007
**AHCCCS EPSDT Tracking Form**

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<tbody>
<tr>
<td>☐ yes</td>
<td>☐ no</td>
<td>☐ yes ☐ no</td>
<td></td>
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</tbody>
</table>

- **Risk indicators of hearing loss:** ☐ yes ☐ 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:**

<table>
<thead>
<tr>
<th>Skin/Hair/Nails</th>
<th>Lungs</th>
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</thead>
<tbody>
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**Assessment/Plan/Follow Up**

<table>
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<tr>
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<th>☐ TB skin test (if at risk)</th>
<th>Other ☐</th>
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<tr>
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<td>☐ Pt. Needs immunization today</td>
<td>☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason</td>
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<tr>
<td>☐ History of chicken pox</td>
<td>☐ HepA</td>
<td>☐ HepB</td>
</tr>
<tr>
<td>☐ MMR</td>
<td>☐ Varicella</td>
<td>☐ DTaP</td>
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<td>☐ Hib</td>
<td>☐ IPV</td>
<td>☐ PCV</td>
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<td>☐ Influenza</td>
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<th>☐ WIC</th>
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See Additional Supervisory note ☐ Yes ☐ No

Revised November 1, 2007
24 Months Old  

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

<table>
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<th>Peds:</th>
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<td>☐ yes</td>
<td>☐ no</td>
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</tbody>
</table>

Risk indicators of hearing loss:  Medications:  Birth Wt:  %  Wt:  %  Ht:  %  Head cir.:  %

☐ yes  ☐ no  ☐ yes  ☐ no

Parental Concerns/History:

Dental Screen: ☐ Indicates guidance given:  ☐ Brushing/flossing (by parent)  ☐ 1st Dental appointment  ☐ White spots on teeth

Nutritional Screen: ☐ Indicates guidance given:  ☐ Feeds self  ☐ Nutritiously 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:

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<tr>
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<tbody>
<tr>
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<tr>
<td>Heart</td>
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</table>

Assessment/Plan/Follow Up

☒ Indicates ordered  ☐ Blood Lead test (perform at 24 months)  ☐ TB skin test (if at risk)  ☐ Other

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

☒ Indicates referred  ☐ CRS  ☐ WIC  ☐ ALTCS  ☐ PT  ☐ OT  ☐ Audiology  ☐ ST  ☐ AzEIP/DDD  ☐ Developmental  ☐ Behavioral  ☐ Dental  ☐ Early Head Start  ☐ Specialty  ☐ Other

Date/Time  Clinician name (print)  Clinician Signature  Note  ☐ Yes  ☐ No

Revised November 1, 2007
### AHCCCS EPSDT Tracking Form

**3 Years Old**

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**Parents Concerns/History:**

**Dental Screen:**

- Yes: Brushing/flossing (by parent) daily
- No: Dental appointment
- Yes: White spots on teeth

**Nutritional Screen:**

- Yes: Nutritionally balanced diet
- No: Junk food
- Yes: Soda/Juice
- No: Over weight
- Yes: Activity
- No: Supplements

**Developmental Screen:**

- Yes: Uses imaginary characters
- No: Matches colors and shapes
- Yes: Counts to 5
- No: Names self and others
- Yes: Knows gender
- No: Begins to play: games with simple rules/interactive games
- Other:

**Age Appropriate Education and Guidance:**

- Yes: Sport helmet use
- No: Drowning prevention
- Yes: Emergency 911
- No: Sun safety
- Yes: Nutrition/exercise
- No: Toilet training
- Yes: Discipline/redirect
- No: Reading/preschool
- Yes: Car Safety/booster seat/5 pt harness
- No: Provide opportunities for pretend & fantasy/problem solving & choices/drawing & scribbling
- Yes: Establish routine for: bed/meals/toileting etc.
- No: Allow child to play independently/be available if child seeks you out
- Other:

**Behavioral Health Screen:**

- Yes: Family adjustment/parent responds positively to child
- No: Self calming
- Yes: “Monster” fear
- No: Frustration/hitting/biting/impulse control
- Yes: Communication/language
- No: Pediatric Symptom Checklist
- Yes: Has words for feelings
- No: Separates easily from parent
- Yes: Objects to major change in routine
- No: Shows interest in other children
- Yes: Feels competent
- No: Kind to animals
- Other:

**Comprehensive Physical Exam:**

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<td>Heart</td>
<td>Neurological</td>
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**Assessment/Plan/Follow Up**

- Yes: Lab ordered
- No: Lab ordered

- White: Hgb/Hct
- Gray: Urinalysis
- Black: TB skin test (if at risk)
- Other: Blood Lead Test (perform at 36 – 72 months if not already done)
- Other: Other

- White: Pt. Needs immunization today
- Gray: Delayed/Deferred
- Black: Parent Refuses
- Other: Other reason

- White: Had chicken pox
- Gray: HepA
- Black: MMR
- Other: Varicella

- White: DTaP
- Gray: Hib
- Black: IPV
- Other: PCV

- White: Influenza
- Gray: Other

- White: Referral
- Gray: CRS
- Black: WIC

- White: Other
- Gray: DDD
- Black: ALTCS

- White: PT
- Gray: OT
- Black: Audiology

- White: ST
- Gray: Developmental

- White: Behavioral
- Gray: Dental
- Black: Head Start

- White: Specialty
- Gray: Other

---

Date/Time: Clinician name (print): Clinician Signature: Note: Yes: No

Revised November 1, 2007
4 Years 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: | PEDS | PEDS Pathway: | Allergies: | Temp: | Pulse: | Resp: | B/P
- | yes | no | OD | OS | OU | Corrected | yes | no | Wt: | % | BMI: | % | Ht: | %
- | refer | refer | Unable to perform | Speech: | age appropriate | yes | no | Medications:

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN: [X] indicates guidance given: □ Brushing/flossing (by parent) daily □ Dental appointment □ White spots on teeth

NUTRITIONAL SCREEN: [X] indicates guidance given: □ Nutritionally balanced diet □ Junk food □ Soda/Juice □ Over weight □ Activity □ Supplements

DEVELOPMENTAL SCREEN: [X] 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: [X] indicates guidance given: □ Sport helmet use □ Drowning prevention □ Emergency 911 □ Sun safety □ Safe at Home □ Nutrition/exercise □ Toilet training □ Discipline/redirection □ 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: [X] 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:

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ASSESSMENT/PLAN/FOLLOW UP

[X] indicates ordered □ Hgb/Hct □ Urinalysis □ TB skin test (if at risk) □ Other
□ Blood Lead Test (perform at 36 – 72 months if not already done)

[X] 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

[X] indicates referred □ CRS □ WIC □ DDD □ ALTCS □ PT □ OT □ Audiology □ Speech
□ Developmental □ Behavioral □ Dental □ Head Start □ Specialty □ Other
5 Years 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:  PEDS  PEDS Pathway:  Allergies:  Temp:  Pulse:  Resp:  B/P

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Corrected  OD  OS  OU

Wt:  %  BM I:  %  Ht:  %

Rt.  pass  refer  Lt.  pass  refer

Unable to perform

Speech: age appropriate  Yes  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:

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ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: □ INDICATES ORDERED

□ Hgb/Hct  □ Urinalysis (to be completed at 5 years)  □ TB skin test (if at risk)

□ Other  □ Blood Lead Test (perform at 36 – 72 months if not already done)

IMMUNIZATIONS: □ INDICATES ORDERED

□ Pt. Needs immunization today □ Delayed/Deferred □ Parent refuses □ Other reason

□ Had chicken pox □ HepA □ HepB □ MMR □ Varicella □ DTaP □ IPV □ Influenza □ Other

REFERRALS: □ INDICATES REFERRED

□ CRS □ WIC □ DDD □ ALTCS □ PT □ OT □ Audiology □ ST

□ Developmental □ Behavioral □ Dental □ Specialty

See Additional Supervisory

Date/Time  Clinician name (print)  Clinician Signature  note  □ Yes □ No

Revised November 1, 2007
### Parental Concerns/History:

**Dental Screen:** [X] indicates guidance given: ☐ Brushing 2x / Flossing daily ☐ Dental appointment ☐ White spots on teeth

**Nutritional Screen:** [X] indicates guidance given: ☐ Nutrientally balanced diet ☐ Junk food ☐ Soda/Juice
☐ Overweight ☐ Activity ☐ Supplements

**Developmental Screen:** [X] indicates accomplishments
☐ Language is expressive and understandable
☐ School attendance
☐ Reading at grade level
☐ Other

**Age Appropriate Education and Guidance:** [X] 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:** [X] 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:

<table>
<thead>
<tr>
<th>Skin/Hair/Nails</th>
<th>Lungs</th>
</tr>
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<tbody>
<tr>
<td>Eyes/Vision</td>
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<tr>
<td>Ear</td>
<td>Genitourinary</td>
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<tr>
<td>Mouth/Throat/Teeth</td>
<td>Extremities</td>
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<td>Nose/Head/Neck</td>
<td>Spine</td>
</tr>
<tr>
<td>Heart</td>
<td>Neurological</td>
</tr>
</tbody>
</table>

### Assessment/Plan/Follow Up

[X] indicates ordered
☐ Hgb/Hct
☐ Urinalysis
☐ TB skin test (if at risk)
☐ Other
☐ Blood Lead Test (perform at 36 – 72 months if not already done)

[X] indicates ordered
☐ Pt. Needs immunization today
☐ Delayed/Deferred
☐ Parent refuses
☐ Other reason
☐ Had chicken pox
☐ HepA
☐ HepB
☐ MMR
☐ Varicella
☐ DTaP
☐ IPV
☐ Influenza
☐ Other

[X] indicates referred
☐ CRS
☐ WIC
☐ DDD
☐ ALTCS
☐ PT
☐ OT
☐ Audiology
☐ ST
☐ Developmental
☐ Behavioral
☐ Dental
☐ Specialty
☐ Other

---

Date/Time       Clinician name (print)       Clinician Signature

See Additional Supervisory note ☐ Yes ☐ No

Revised November 1, 2007
### 7 – 8 Years Old

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<tr>
<th>Date</th>
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<th>PCP ph. #</th>
<th>Health Plan</th>
<th>Accompanied by (name)</th>
<th>Relationship</th>
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<tbody>
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### NICU: × yes □ no □ yes □ no

### PEDS Pathway:

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### Allergies: □ yes □ no

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<th>Resp:</th>
<th>B/P</th>
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<table>
<thead>
<tr>
<th>Speech: age appropriate</th>
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### Medications:

### Parental/Patient Concerns/History:

**Dental Screen:**
- □ Bracing 2x /Flossing daily
- □ Dental appointment
- □ White spots on teeth

**Nutritional Screen:**
- □ Nutritionally balanced diet
- □ Junk food
- □ Soda/Juice
- □ Over weight
- □ Activity
- □ Supplements

**Developmental Screen:**
- □ School attendance
- □ Reading at grade level
- □ Other

**Age Appropriate Education and Guidance:**
- □ 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:**
- □ Family adjustment/parent responds positively to child
- □ Frustration /impulse control
- □ Communication/language
- □ Comfortable body image
- □ Pediatric Symptom Checklist
- □ Other

### Comprehensive Physical Exam:

<table>
<thead>
<tr>
<th>Skin/Hair/Nails</th>
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</tr>
</thead>
<tbody>
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<td>Eyes/Vision</td>
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<td>Spine</td>
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<tr>
<td>Heart</td>
<td>Neurological</td>
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</tbody>
</table>

### Assessment/Plan/Follow Up

**Laboratory Tests Ordered:**
- □ Hgb/Hct
- □ Urinalysis
- □ TB skin test (if at risk)
- □ Other

**Immunization Status:**
- □ Pt. Needs immunization today
- □ Delayed
- □ Deferred
- □ Hep A
- □ MMR
- □ Varicella
- □ Td
- □ Influenza
- □ Hep B
- □ IPV
- □ Other

**Referred Services:**
- □ CRS
- □ WIC
- □ DDD
- □ ALTCS
- □ PT
- □ OT
- □ Audiology
- □ ST
- □ Developmental
- □ Behavioral
- □ Dental
- □ Specialty

### Additional Supervisory Notes

Revised November 1, 2007
<table>
<thead>
<tr>
<th>Date</th>
<th>Last Name</th>
<th>First Name</th>
<th>AHCCCS ID #</th>
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<tr>
<th>Primary Care Provider</th>
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<th>Abnl</th>
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<th>Menses</th>
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<tbody>
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</tbody>
</table>

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: □ Nutritionalized 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:**

<table>
<thead>
<tr>
<th>Skin/Hair/ Nails</th>
<th>Lungs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes/Vision</td>
<td>Abdomen</td>
</tr>
<tr>
<td>Ear</td>
<td>Genitourinary Tanner stage</td>
</tr>
<tr>
<td>Mouth/Throat/Teeth</td>
<td>Extremities</td>
</tr>
<tr>
<td>Nose/Head/Neck</td>
<td>Spine</td>
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<tr>
<td>Heart</td>
<td>Neurological</td>
</tr>
</tbody>
</table>

**ASSESSMENT/PLAN/FOLLOW UP**

<table>
<thead>
<tr>
<th>□ INDICATES ORDERED</th>
<th>□ Hgb/Hct</th>
<th>□ Urinalysis</th>
<th>□ Lipid Profile</th>
<th>TB skin test (if at risk) □ Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ INDICATES ORDERED</td>
<td>□ Pt. Needs immunization today □ Delayed □ Deferred</td>
<td></td>
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</tr>
<tr>
<td>□ Tdap (11 - 12 years only) □ Meningococcal (11 – 12 years only) □ HPV (11 – 12 years) □ Hepatitis A □ MMR □ Varicella □ Hepatitis B □ Td □ Influenza □ IPV □ Other</td>
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<td>□ INDICATES REFERRED</td>
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<tr>
<td>□ Developmental □ Behavioral □ Dental □ Specialty</td>
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Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note □ Yes □ No

Revised November 1, 2007
## 13 – 17 Years Old

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<th>First Name</th>
<th>AHCCCS ID #</th>
<th>DOB</th>
<th>Age</th>
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</thead>
</table>

### Primary Care Provider
- PCP ph. #

### Health Plan

### Accompanied by (name)
- Relationship

### Vision Chart Exam
- OD
- OS
- OU

### Audiometry

### Menses

### Allergies:
- yes
- no

### B/P

### Temp:

### Pulse:

### Resp:

### Corrected
- yes
- no

### Unable to perform

### Meds:

### Parent/Patient Concerns/History:

### HEALTH RISK ASSESSMENT:
- HEADDSS
- GAPS
- Other

### DENTAL SCREENING:
- Brushing 2x/Flossing daily
- Dental appointment
- White spots on teeth

### NUTRITIONAL SCREEN:
- Nutritionally balanced diet
- Junk food
- Soda/Juice
- Over weight
- Activity
- Supplements

### DEVELOPMENTAL SCREEN:
- 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:
- 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:
- Comfortable body image
- Other

### COMPREHENSIVE PHYSICAL EXAM:

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

### ASSESSMENT/PLAN & FOLLOW UP

- □ Indicates ordered
  - Hgb/Hct
  - U/A (preferred at 16 yrs)
  - 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
  - Specialty

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**Revised November 1, 2007**
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**Medications:**

**Patient Concerns/History:**

**HEALTH RISK ASSESSMENT:**

- **HEADDSS**: Boxed items indicate assessment used.
- **GAPS**: Boxed items indicate assessment used.
- **Other**: Boxed items indicate assessment used.

**DENTAL SCREENING:**

- **Brushing 2x**: Boxed items indicate guidance given.
- **Flossing daily**: Boxed items indicate guidance given.
- **Dental appointment**: Boxed items indicate guidance given.
- **White spots on teeth**: Boxed items indicate guidance given.

**NUTRITIONAL SCREEN:**

- **Nutritionally balanced diet**: Boxed items indicate guidance given.
- **Junk food**: Boxed items indicate guidance given.
- **Soda/ Juice**: Boxed items indicate guidance given.

**DEVELOPMENTAL SCREEN:**

- **Late Adolescence**: Boxed items indicate guidance given.
- **Abstract thinking**: Boxed items indicate guidance given.
- **School attendance**: Boxed items indicate guidance given.
- **Sexuality/orientation**: Boxed items indicate guidance given.
- **Other**: Boxed items indicate guidance given.

**AGE APPROPRIATE EDUCATION AND GUIDANCE:**

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

**BEHAVIORAL HEALTH SCREEN:**

- **Philosophical/idealistic**: Boxed items indicate observed by clinician/parent report.
- **Comfortable body image**: Boxed items indicate observed by clinician/parent report.
- **Building intimate, complex relationships**: Boxed items indicate observed by clinician/parent report.

**COMPREHENSIVE PHYSICAL EXAM:**

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<tr>
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**ASSESSMENT/PLAN/FOLLOW UP**

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<tbody>
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</tbody>
</table>

**IMMUNIZATIONS:**

- **Pt. Needs immunization today**: Boxed items indicate order given.
- **Delayed**: Boxed items indicate order given.
- **Deferred**: Boxed items indicate order given.
- **Hepatitis A**: Boxed items indicate order given.
- **MMR**: Boxed items indicate order given.
- **Varicella**: Boxed items indicate order given.
- **Hepatitis B**: Boxed items indicate order given.
- **Td**: Boxed items indicate order given.
- **Influenza**: Boxed items indicate order given.
- **Meningococcal**: Boxed items indicate order given.
- **HPV**: Boxed items indicate order given.
- **IPV**: Boxed items indicate order given.
- **Tdap**: Boxed items indicate order given.
- **Other**: Boxed items indicate order given.

**REFERRALS:**

- **CRS**: Boxed items indicate referred.
- **WIC**: Boxed items indicate referred.
- **DDD**: Boxed items indicate referred.
- **ALTCS**: Boxed items indicate referred.
- **PT**: Boxed items indicate referred.
- **OT**: Boxed items indicate referred.
- **Speech**: Boxed items indicate referred.
- **Developmental**: Boxed items indicate referred.
- **Behavioral**: Boxed items indicate referred.
- **Dental**: Boxed items indicate referred.
- **OB/Gyn**: Boxed items indicate referred.
- **Specialty**: Boxed items indicate referred.

**See Additional Supervisory**

**Date/Time**

Clinician name (print)  Clinician Signature  note  Yes  No

Revised November 1, 2007
APPENDIX H:

MAP AND NAMES/TELEPHONE OF RBHAS

AND

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

APIPA - Arizona Physician’s I.P.A.
NARBHA - Northern Arizona Regional Behavioral Health Authority
CPSA - Community Partnership of Southern Arizona

Rev. 10/1/08
### Regional Behavioral Health Authorities (RBHAs)

<table>
<thead>
<tr>
<th>NAME</th>
<th>COUNTIES OF OPERATION</th>
<th>MEMBER SERVICES NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Magellan</td>
<td>Maricopa</td>
<td>800-564-5465</td>
</tr>
<tr>
<td>Community Partnership of Southern Arizona (CPSA)</td>
<td>Pima, Santa Cruz, Cochise, Graham, Greenlee</td>
<td>800-771-9889 After 11 p.m. calls roll over to SAMHC (staffed 24 hours)</td>
</tr>
<tr>
<td>Northern Arizona Regional Behavioral Health Authority (NARBHA)</td>
<td>Coconino, Mohave, Navajo, Apache, Yavapai</td>
<td>928-774-7128 800-640-2123 After 5 p.m., calls roll over to an answering service. Crisis calls are directed to crisis providers.</td>
</tr>
<tr>
<td>Cenpatico</td>
<td>Pinal, Gila, Yuma, La Paz</td>
<td>Member Services 866-495-6738 Pinal County Gila County Yuma County La Paz County</td>
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### Tribal Regional Behavioral Health Authorities and Contractors

<table>
<thead>
<tr>
<th>NAME</th>
<th>MEMBER SERVICES NUMBER</th>
<th>WEB SITE ADDRESS</th>
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</thead>
<tbody>
<tr>
<td>Gila River Tribal Regional Behavioral Health Authority</td>
<td>602-528-7100</td>
<td><a href="http://www.gilariverrbha.org/index/htm">http://www.gilariverrbha.org/index/htm</a></td>
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<tr>
<td>Navajo Nation Behavioral Health Contractor</td>
<td>928-871-6877</td>
<td><a href="http://www.navajo.org/">http://www.navajo.org/</a></td>
</tr>
<tr>
<td>White Mountain Apache Tribe</td>
<td>928-338-4811</td>
<td><a href="http://www.wmabhs.org">http://www.wmabhs.org</a></td>
</tr>
</tbody>
</table>

Rev. 10/1/08
I. Information on Person Making Referral

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 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
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.****

Last revision: 05/08/2009
Effective date: 07/01/2009
APPENDIX I:

CULTURALLY COMPETENT PATIENT CARE:

A GUIDE FOR PROVIDERS AND THEIR STAFF
ACKNOWLEDGEMENTS

This pocket guide is made possible through the collaborative efforts of the following organizations:

**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

**With Special Thanks to:**

- Phil Nieri, Health Choice Arizona
- Susan Cypert, Mercy Care Health Plan
- Ginger Clubine, CIGNA
- David Brooks
<table>
<thead>
<tr>
<th>Section One</th>
<th>Introduction</th>
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<td>Section Two</td>
<td>Health Beliefs, Attitudes, and Behaviors: Implications for Clinical Care</td>
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<td>Section Three</td>
<td>Strategies and Approaches in Assessing Patients’ Beliefs about Health and Illness</td>
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<td>Section Four</td>
<td>Effective Patient Communication and Education Strategies</td>
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<td>Section Five</td>
<td>Resources</td>
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</tbody>
</table>
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
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.

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

Source:
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.)
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, housekeeping 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.
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:


- National Center for Cultural Competence: Bureau of Primary Health Care Component

- 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):


- 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/


- Health and Human Services: Health Resources and Services Admin.: news articles http://www.hrsa.dhhs.gov/


- Bureau of Primary Health Care Supported Community Health Programs  http://www.bphc.hrsa.dhhs.gov/databases/fqhc/fqhcquery.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
Peer Review

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).

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.

Issue/Revision Date: March 2, 2009
Approved by AHCCCS: 3/4/09
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.

Issue/Revision Date: March 2, 2009
Approved by AHCCCS: 3/4/09
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 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 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

Issue/Revision Date: March 2, 2009
Approved by AHCCCS: 3/4/09
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.