300 CHAPTER OVERVIEW

REVISION DATE: 5/13/2016, 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994

The services described in this Chapter are available to members enrolled in Title XIX. This includes Targeted (Title XIX Acute) and Arizona Long Term Care Services (ALTCS) members.

Contracted Health Plans

Members who are eligible for Long Term Care services are required to join one of the Division's contracted health plans, where available. The exception is Native Americans who may choose to enroll in American Indian Health Plan.

The contracted health plan subcontracts with physicians, hospitals, therapists, dentists, laboratories, pharmacies, medical equipment suppliers, and other providers to deliver acute care services to enrolled members.

All services must be delivered or ordered by the Primary Care Provider (PCP), determined to be medically necessary by the health plan and delivered by a contracted provider. The PCP is the member's designated physician who coordinates all aspects of the member's medical care. Members who are eligible for Long Term Care services that fail to follow these procedures and receive services that are not approved/provided by a health plan provider are responsible to pay for these services.

The members who are eligible for Long Term Care services may choose to use their own doctor if the physician is an Arizona Health Care Cost Containment System (AHCCCS) registered provider and is contracted with the health plan. In these instances, the health plan's or the Division's approval is still needed for services covered by Arizona Long Term Care System (ALTCS).

If the member who is long term care eligible is enrolled in a health plan and has a PCP, but also chooses to use another physician who may not be registered with AHCCCS, services provided or ordered by this physician are not covered by the AHCCCS. Services by a physician who is not registered with the AHCCCS can be covered by the health plan if approved by the PCP and the health plan. If approval is not received from the PCP and the health plan, the member will be required to pay for the services personally or through private insurance.

Children's Rehabilitative Services

Members eligible for ALTCS may also be eligible for Children's Rehabilitative Services (CRS). Members eligible for the Division and CRS will receive CRS specialty services and behavioral health services through United Healthcare Community Plan or its successor. These members will continue to receive acute care services through their Division acute health plan.

Extended Care Coverage

Health plans for members who are eligible for Long Term Care are financially responsible for a maximum of 90 days. This financial responsibility includes nursing facility care, and room and board, after hospital discharge. Nursing Facility (NF) care must be in lieu of hospitalization. If the member's place of residence prior to hospitalization was a NF the health plan is not financially responsible for placement. Members requiring nursing facility placement beyond 90 days are the financial responsibility of the Division. Preadmission Screening/Annual Resident Review (PASRR) Level II reviews must occur for each member whose expected stay in the NF will exceed 90 days.

Division staff will work expeditiously with the health plan's discharge planners to place the member in the least restrictive environment as required by state law.

Comprehensive Medical and Dental Program

The Comprehensive Medical and Dental Program (CMDP) is a health care program for Arizona's children who are wards of the court and placed out of home. Eligibility is based on State law. Department of Child Safety (DCS) coordinates services related to CMDP.

Member Acute Care Card

Members who are determined eligible for Long Term Care services will receive a membership card from the Division or the Division's contracted acute health plan, and will be enrolled in a contracted acute health plan by the Division or receive services on a fee-for-service basis through the Division.

Health Plan Responsibilities

Each contracted acute health plan is required to send members a health plan member handbook. The handbook explains the services that are covered, how to access these services, and what to do when emergency services are needed. It outlines the member's responsibility to follow procedures. All services must be provided or approved by the primary care provider

An ALTCS member who fails to follow procedures outlined in the member handbook and receives services that are not approved or provided by a health plan contracted physician may be responsible to pay for those services.

The Division may delegate some or all of its responsibility to a health plan for the following non-inclusive health care responsibilities. These services are rendered on behalf of members who are ALTCS members and enrolled with the health plan:

A. Prior authorization of services and procedures as specified by the health plan.

B. Claims processing according to policies and procedures defined by the health plan.

C. Concurrent review, including certification and denial of inpatient hospital stay days, according to health plan procedures.

D. Investigation and resolution of complaints and grievances according to policy and procedure specified by both AHCCCS and the health plan.

E. Provider relations and member services activities.

F. Financial monitoring and reporting as mandated under AHCCCS rules.

G. All other quality assurance and utilization management activities as defined in the Title 42 of the Code of Federal Regulations (http://www.gpoaccess.gov/cfr/), AHCCCS Rules (azahcccs.gov/Regulations/), and the health plan's quality assurance/utilization review procedures.

All such services/responsibilities must be in compliance with AHCCCS/ALTCS Rules and Regulations (azahcccs.gov/Regulations/Arizona).

310-A AUDIOLOGY

EFFECTIVE DATE: March 3, 2017

REFERENCES: 42 CFR 440.110

The Division of Developmental Disabilities (Division) covers medically necessary audiology services to evaluate hearing loss for all members, on an inpatient and outpatient basis. Only an AHCCCS-registered dispensing audiologist or an AHCCCS-registered individual with a valid hearing aid dispensing license may dispense hearing aids. Hearing aids, provided as a part of audiology services, are covered only for members for members age 21 and under who are eligible for AHCCCS.

Audiology services must be provided by an audiologist who is licensed by the Arizona Department of Health Services (ADHS) and who meets the federal requirements specified under Title 42 of the Code of Federal Regulations (42 CFR 440.110). Out-of-state audiologists must meet the federal requirements.

The federal requirements mandate that the audiologist have a master's or doctoral degree in audiology and meet one of the following conditions:

A. Have a certificate of clinical competence in audiology granted by the American Speech-Language-Hearing Association (ASHA), or

B. Have successfully completed a minimum of 350 clock-hours of supervised clinical practicum (or be in the process of accumulating such supervised clinical experience under the supervision of a qualified master's or doctoral-level audiologist), performed at least nine months of supervised full-time audiology services under the supervision of a qualified master or doctoral-level audiologist after obtaining a master's or doctoral degree in audiology or a related field, and successfully completed a national examination in audiology approved by the Secretary of the U.S. Department of Health and Human Services.

310-D DENTAL SERVICES

REVISION DATE: 10/14/2016, 7/3/2015, 4/17/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994
REFERENCES: A.R.S. § 32-1207 and 32-1231.

Dental Services for Members Aged 0-21

Dental services for members who are Arizona Long Term Care System (ALTCS) eligible aged 0 to 21 years are covered when provided by a dentist licensed per A.R.S. § 32-1207 and A.R.S. § 32-1231 for maintenance of dental health, prevention and treatment of disease and injury, in an appropriate dental facility.

Informed consent must be obtained from the member or responsible person(s) prior to any treatment including those noted in covered services. Written consent must be obtained prior to major outpatient treatments. The dentist must obtain the consent.

The following services are covered:

A. Preventive dental services - performed annually unless otherwise requested by Primary Care Provider (PCP) include:

   1. Oral examinations
   2. Radiological and medical imaging services
   3. Oral prophylaxis - includes scaling and polishing and application of topical fluoride and sealants, if appropriate
   4. Dental treatment plan
   5. Dental education

B. Restorative treatment, including:

   1. Restorative and primary amalgams
   2. Composite restoration (anterior teeth)
   3. Sedative base
   4. Permanent teeth

C. Orthodontia when medically necessary and prior authorized by the health plan or the Division's Medical Director.

D. Endodontic services (pulp capping, pulpotomy, and recalcification)

E. Crown and bridge services

F. Prosthetics

G. Oral surgery (includes extraction of symptomatic teeth and post-operative visits)

H. Orthognathic surgery

I. Medically necessary dentures.

Dental Services for Members Aged 21 and Older

Dental services, including dentures, are covered for AHCCCS ALTCS members 21 years of age and older. Dental services are limited to a total benefit amount of $1,000 per member for each 12-month period beginning October 1, 2016 through September 30, 2017.

Emergency Dental Care/Extractions for ALTCS Members of All Ages

Emergency dental care and extractions are covered for all members who are eligible for ALTCS regardless of age.

310–E DIALYSIS

EFFECTIVE DATE: March 3, 2017

The Division of Developmental Disabilities (Division) covers hemodialysis and peritoneal dialysis are covered services when provided by participating hospitals and End Stage Renal Disease facilities. All services, supplies, diagnostic testing (including routine medically necessary laboratory tests), and drugs medically necessary for the dialysis treatment are covered.

A. Medically necessary outpatient dialysis treatments are covered. Inpatient dialysis treatments are covered when the hospitalization is for the following:

   1. Acute medical condition requiring dialysis treatments (hospitalization related to dialysis)

   2. Division-covered medical condition requiring inpatient hospitalization experienced by a member routinely maintained on an outpatient chronic dialysis program

   3. Placement, replacement, or repair of the chronic dialysis route.

B. Hospital admissions solely to provide chronic dialysis are not covered.

C. Hemoperfusion is covered when medically necessary.

310-F EMERGENCY MEDICAL SERVICES

REVISION DATE: 11/17/2017, 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 2014
REFERENCES: A.A.C. R9-22-210.

The Division of Developmental Disabilities (Division) covers emergency medical services for members eligible for ALTCS and Fee For Service (FFS)/American Indian Health Plan (AIHP). Emergency medical services are provided for the treatment of an emergency medical condition. An emergency medical condition is a medical condition, including labor and delivery, which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate attention to result in **any** of the following:

A. Placement of the patient's health in serious jeopardy

B. Serious impairment of bodily functions

C. Serious dysfunction of any bodily organ or part.

Emergency medical services are covered when there is a demonstrated need and/or after triage/emergency medical assessment services indicate an emergency condition.

A provider is not required to obtain prior authorization for emergency services.

Providers must notify the health plan within 12 hours of emergency service provision. Non-emergency services out of the member's service area may not be covered.

Emergency services may be obtained when the member is out of the service area.

Emergency Services will not be provided to a member outside the United States.

Use of Emergency Services

The Division and its Administrative Services Subcontractors must educate their members regarding the appropriate use of emergency room services. Members should be encouraged to obtain services from non-emergency facilities (e.g., urgent care centers) to address member non-emergency care after regular office hours or on weekends.

310-H HEALTH RISK ASSESSMENT AND SCREENING TESTS

EFFECTIVE DATE: MAY 13, 2016

A. The Division covers health risk assessment and screening tests provided by a physician, primary care provider or other licensed practitioner within the scope of his/her practice under State law for all members.

B. These services include appropriate clinical heath risk assessments and screening tests, immunizations, and health education, as appropriate for age, history and current health status. Health risk assessment and screening tests are also covered for members under the Early and Periodic Screening, Diagnosis and Treatment Program.

C. Preventive health risk assessment and screening test services are covered for adults, except when the adult member is hospitalized. Services include, but are not limited to:

1. Hypertension screening (annually).

2. Cholesterol screening (once, additional tests based on history).

3. Routine mammography annually after age 40 and at any age if considered medically necessary.

4. Cervical cytology, including pap smears (annually for sexually active women; after three successive normal exams the test may be less frequent).

5. Colon cancer screening (digital rectal exam and stool blood test, annually after age 50, as well as baseline colonoscopy after age 50).

6. Sexually transmitted disease screenings (at least once during pregnancy, other based on history).

7. Tuberculosis screening (once, with additional testing based on history, or, for members residing in a facility, as necessary per health care institution licensing requirement).

8. HIV screening.

9. Immunizations (See AHCCCS Policy AMPM 310 M for details).

10. Prostate screening (annually after age 50; and, screening is recommended annually for males 40 and older who are at high risk due to immediate family history), and

11. Physical examinations (includes well visits and well exams), periodic health

examinations or assessments, diagnostic work ups or health protection packages designed to:

a. Provide early detection of disease,

b. Detect the presence of injury or disease,

c. Establish a treatment plan,

d. Evaluate the results or progress of a treatment plan or the disease, or

e. Establish the presence and characteristics of a physical disability, which may be the result of disease or injury.

D. Screening services provided more frequently than these professionally recommended guidelines will not be covered unless medically necessary.

Exclusions

Physical examinations not related to covered health care services or performed to satisfy the demands of outside public or private agencies such as the following are not covered services:

A. Qualification for insurance.

B. Pre-employment physical examination.

C. Qualifications for sports or physical exercise activities.

D. Pilots examinations (Federal Aviation Administration).

E. Disability certification for the purpose of establishing any kind of periodic payments.

F. Evaluation for establishing third party liability.

310-I HOME HEALTH SERVICES

REVISION DATE: 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994

Home health services through the health plan are those services provided by a Home Health Agency that coordinate in-home intermittent services. These services include, home health aide services, medical supplies, equipment and appliances. The service must be ordered by the Primary Care Provider (PCP) in lieu of hospitalization and referred by the health plan to a Medicare Certified Home Health Agency.

Travel Expenses (Meals, Lodging, Transportation and Attendant Services)

Expenses incurred for meals, lodging, and transportation for a member while en route to or from a health care service site out of the member's service area or county of residence are covered services.

The PCP must write an order for attendant care services. The Attendant Care Provider's meals, lodging, and transportation expenses are covered. On occasion the Attendant Care Provider may accompany a member out of the service area or county of residence. These attendant care providers may also be a family member who lives in the same household as the member. Under these circumstances services are covered if a written order from the PCP is issued. The Attendant Care Provider's salary is covered only if the attendant does not live in the same household as the member. Expense receipts must be sent to the health plan or Health Care Services for fee-for-service counties. Receipts for meals and lodging must not exceed the State per diem. Transportation will be reimbursed at 9 cents per mile.

The following exclusions and limitations apply:

A. Family household members, friends, and neighbors may be reimbursed for providing transportation services only if the services are ordered in writing by the PCP and free transportation or public transportation is not available;

B. A charitable organization providing transportation services at no cost. A charitable organization may not charge or seek reimbursement for the provision of such services to Arizona Long Term Care System (ALTCS); and,

C. Payment for meals, lodging, and transportation of a member, and an Attendant Care Provider, are funded when a member requires covered service that are not available in the health plan's service area. This criterion also applies to the salary for an attendant.

310–J HOSPICE SERVICES

EFFECTIVE DATE: November 17, 2017

REFERENCES: A.R.S. §§ 36-2907 and 2989, 42 CFR 418.20 and 70, Arizona's Section 115(a) Medicaid Demonstration Extension.

Hospice services are covered for members eligible for AHCCCS. Hospice services are allowable under A.R.S. §§ 36-2907 and 2989, and 42 CFR 418.20, for terminally ill members who meet the specified medical criteria/requirements. Hospice services provide palliative and support care for terminally ill members and their family members or caregivers in order to ease the physical, emotional, spiritual, and social stresses, which are experienced during the final stages of illness and during dying and bereavement.

Hospice services are provided in the member's own home, an alternative residential setting, or the following inpatient settings when the conditions of participation are met as specified in 42 CFR 418:

A. Hospital

B. Nursing care institution

C. Freestanding hospice.

Providers of hospice must be Medicare certified, licensed by the Arizona Department of Health Services (ADHS), and have a signed AHCCCS provider agreement.

As directed by the Affordable Care Act, members receiving Early Periodic Screening, Diagnosis, and Treatment (EPSDT) may continue to receive curative treatment for their terminal illness while receiving hospice services. Adult members age 21 and older who elect hospice services must forgo curative care.

For dual eligible members, Medicare is the primary payer of hospice services.

Definitions

The following definitions apply to Hospice Services:

A. Continuous home care - hospice provided during periods of crisis for a minimum of eight hours per 24-hour day (the hours do not have to be continuous). To qualify as home care under this section, the care must be predominantly nursing care, provided by a registered nurse or a licensed practical nurse. Homemaker and home health aide services may also be provided to supplement the care. Continuous home care is only furnished during brief periods of crisis and only as necessary to allow terminally ill hospice-eligible members to maintain residence in their own home or an alternative residential setting. Continuous home care is not available to members residing in a Nursing Facility (NF) Medicaid certified bed.

B. Inpatient respite care - services provided in an inpatient setting, such as an NF, on a short-term basis to relieve family members or other caregivers who provide care to members eligible for hospice who have elected to receive hospice care and who reside in their own home or, home and community based (HCB) alternative

residential setting.

C. General inpatient care - services provided, in an inpatient setting such as a hospital, to members eligible for hospice who have elected to receive hospice. These services are provided for such purposes as pain control or acute or chronic symptom management, which cannot be performed in another setting.

D. Period of crisis - a period in which the hospice-eligible member requires continuous care to achieve palliation or management of acute medical symptoms.

E. Routine home care - short-term, intermittent hospice including skilled nursing, home health aide and/or homemaker services provided to a hospice-eligible member in his or her own home or an alternative residential setting. Routine home care services may be provided on a regularly scheduled and/or on-call basis. The member eligible for hospice must not be receiving continuous home care services as defined in this section at the time routine home care is provided. Routine home care is available to members residing in an NF Medicaid certified bed.

Amount, Duration and Scope

Prior to the member receiving hospice services, the physician must provide certification stating that the member's prognosis is terminal with the member's life expectancy not exceeding six months. Due to the uncertainty of predicting courses of illness, the hospice benefit is available beyond six months provided additional physician certifications are completed.

The physician certification is permitted for two 90-day periods; thereafter, an unlimited number of physician certifications for 60-day periods are permitted.

State licensure standards for hospice care require providers to include skilled nursing, respite, and bereavement services. Hospice providers must also have social services, counseling, dietary services, homemaker, personal care and home health aide services, and inpatient services, available as necessary to meet the member's needs. The following components are included in hospice service reimbursement, if they are provided in approved settings:

A. Bereavement services, including social and emotional support provided by the hospice provider, to the member's family both before and up to twelve months following the death of that member

B. Continuous home care (as specified in this policy), which may be provided only during a period of crisis

C. Dietary services, which include a nutritional evaluation and dietary counseling when necessary

D. Home health aide services

E. Homemaker services

F. Nursing services provided by or under the supervision of a registered nurse

G. Pastoral/counseling services provided by an individual who is qualified through the completion of a degree in ministry, psychology, or a related field, and who is appropriately licensed or certified

H. Hospice respite care services that are provided on an occasional basis, not to exceed more than five consecutive days at a time

(Hospice respite care services may not be provided when the member is residing in a nursing facility or is receiving services in an inpatient setting indicated above.)

I. Routine home care, as specified in the definition of hospice services

J. Social services provided by a qualified social worker

K. Therapies that include physical, occupational, respiratory, speech, music, and recreational therapy

L. Twenty-four hour on-call availability to provide services such as reassurance, information and referral, for members and their family members or caretakers

M. Volunteer services provided by individuals who are specially trained in hospice and who are supervised by a designated hospice employee

(Under 42 CFR 418.70, if providing direct patient care, the volunteer must meet qualifications required to provide such services.)

N. Medical supplies, appliances, and equipment, and pharmaceuticals used in relationship to the palliation or management of the member's terminal illness. Appliances may include durable medical equipment such as wheelchairs, hospital beds or oxygen equipment.

310-K HOSPITAL INPATIENT SERVICES

REVISION DATE: 11/17/2017, 7/3/2015, 3/2/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994
REFERENCES: A.R.S. § 32-801 through 871

The Division of Developmental Disabilities (Division) covers medically necessary inpatient hospital services, provided by a licensed participating hospital, for all members eligible for ALTCS. Inpatient hospital services are medically necessary services delivered or directed by a Primary Care Provider (PCP), a specialist physician, practitioner or dentist. These services are ordinarily furnished in an acute care hospital, except for services in public or correctional facilities, or Behavioral Health settings.

Inpatient hospital services for members include, but are not limited to, the following:

A. Hospital accommodation, and appropriate staffing, supplies, equipment and services for any or all of the following:

1. Routine acute medical care
2. Intensive care and coronary care
3. Neonatal intensive care
4. Maternity care including labor, delivery and recovery rooms, birthing centers, and nursery and related services
5. Nursery for newborns and infants
6. Surgery including surgical suites and recovery rooms, and anesthesiology services
7. Acute behavioral health emergency services
8. Nursing services necessary and appropriate for the member's medical condition, including assistance with activities of daily living as needed
9. Dietary services
10. Medical supplies, appliances and equipment consistent with the level of accommodation
11. Perfusion and perfusionist services.

B. Ancillary Services

Ancillary services include any or all of the following:

1. Chemotherapy
2. Dental surgery for members in the Early and Periodic Screening, Diagnosis and Treatment Program, also known as “EPSDT”

3. Dialysis
4. Laboratory services
5. Pharmaceutical services and prescribed drugs
6. Radiological and medical imaging services
7. Rehabilitation services including physical, occupational and speech therapies
8. Respiratory therapy
9. Services and supplies necessary to store, process, and administer blood and blood derivatives
10. Total parenteral nutrition.

Limitations and Exclusions

The Division covers semiprivate inpatient hospital accommodations, except when the member's medical condition requires isolation.

The Division does not separately cover home-based services, such as Attendant/Personal Care, while the member is in inpatient settings.

310-L HYSTERECTOMY

EFFECTIVE DATE: November 17, 2017
REFERENCES: 42 CFR 441.250 et seq

Medically necessary hysterectomy services are covered in accordance with federal regulations 42 CFR 441.250 et seq. Federal regulation 42 CFR 441.251 defines a *hysterectomy* as "a medical procedure or operation for the purpose of removing the uterus." *Sterilization* is defined by this regulation as "any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing."

The Division does not cover a hysterectomy procedure if:

A. It is performed solely to render the individual permanently incapable of reproducing, or

B. There was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

Coverage of hysterectomy services is limited to those cases in which medical necessity has been established by careful diagnosis and there has been a trial of medical or surgical therapy which has not been effective in treating the member's condition, except for those conditions as specified below.

Examples of Conditions When Hysterectomy May Be Indicated

A. Dysfunctional Uterine Bleeding or Benign Fibroids associated with Dysfunctional Bleeding: A hysterectomy may be considered for members for whom medical and surgical therapy has failed, and childbearing is no longer a consideration.

B. Endometriosis: A hysterectomy may be considered for members with severe disease when future child-bearing is not a consideration, and when disease is refractory to medical or surgical therapy.

C. Uterine Prolapse: A hysterectomy may be considered for the symptomatic women for whom childbearing is no longer a consideration and for whom non-operative and/or surgical correction (i.e., suspension or repair), will not provide the member adequate relief.

Conditions Where Therapy Is Not Required Prior to Hysterectomy

Hysterectomy services may be considered medically necessary *without prior trial of therapy* in the following cases:

A. Invasive carcinoma of the cervix

B. Ovarian carcinoma

C. Endometrial carcinoma

D. Carcinoma of the fallopian tube

E. Malignant gestational trophoblastic disease

F. Life-threatening uterine hemorrhage, uncontrolled by conservative therapy

G. Potentially life-threatening hemorrhage as in cervical pregnancy, interstitial pregnancy, or placenta abruption.

The provider is not required to complete a Consent to Sterilization form prior to performing hysterectomy procedures and the 30-day waiting period required for sterilization does not apply to hysterectomy procedures described in this section.

Prior Acknowledgment and Documentation

Except as described in *Exceptions from Prior Acknowledgement* below, the provider must comply with the following requirements **prior** to performing the hysterectomy:

A. Inform the member and her representative, if any, both orally and in writing that the hysterectomy will render the member incapable of reproducing (i.e., result in sterility).

B. Allow 30-day waiting period.

C. Obtain from the member or representative, if any, a signed, dated written acknowledgment stating that the information in "A" above has been received and that the individual has been informed and understands the consequences of having a hysterectomy (i.e., that it will result in sterility). This documentation must be kept in the member's medical record. A copy must also be kept in the member's medical record maintained by the primary care provider if enrolled with an Administrative Services Subcontractor.

Exceptions from Prior Acknowledgement

The physician performing the hysterectomy is not required to obtain prior acknowledgment in either of the following situations:

A. The member was already sterile before the hysterectomy. In this instance the physician must certify in writing that the member was already sterile at the time of the hysterectomy and specify the cause of sterility.

B. The member requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgement is not possible. In this circumstance, the physician must certify in writing that the hysterectomy was performed under a life-threatening emergency situation in which the physician determined that prior acknowledgement was not possible.

310–M IMMUNIZATIONS

EFFECTIVE DATE: November 17, 2017
REFERENCES: AMPM Chapter 400

Immunizations are covered as appropriate for age, history, and health risk, for adults and children.

The Division of Developmental Disabilities (Division) follows recommendations as established by the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP). Covered immunizations for adults include, but are not limited to:

A. Diphtheria-tetanus

B. Influenza

C. Pneumococcus

D. Rubella

E. Measles

F. Hepatitis-B

G. Pertussis, as currently recommended by the CDC or ACIP

H. Zoster vaccine, for members 60 and older

I. HPV vaccine, for females and males up to age 26 years. Covered immunizations for children are identified in AMPM Chapter 400.

Immunizations for passport or visa clearance are not covered.

The Division does not require prior authorization for medically necessary immunization services performed by Fee-For-Service providers.

310-N LABORATORY

REVISION DATE: 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994

Clinical Laboratory, Radiological and Medical Imaging Services (Acute Care Services)

Clinical laboratory procedures (including routine screening for Hepatitis B), radiological and medical imaging services prescribed by a Primary Care Provider (PCP) or by another physician, practitioner, or dentist upon referral by a PCP, and which are ordinarily administered in hospitals, clinics, physicians' offices or other health care facilities by licensed health care providers, shall qualify as covered services if medically necessary.

Clinical laboratory, radiological, and medical imaging service providers shall satisfy all applicable State license and certification requirements, be registered with the Arizona Health Care Cost Containment System (AHCCCS), and shall perform only those services specific to their license and certification.

310-O MATERNAL AND CHILD HEALTH SERVICES

EFFECTIVE DATE: March 3, 2017

The Division of Developmental Disabilities covers a comprehensive set of services for pregnant women, newborns, and children that includes maternity care, family planning services, and services provided through the Early and Periodic Screening, Diagnosis and Treatment Program.

Refer to Chapter 400 of this Manual for a complete discussion of covered maternal and child health services.

310-P MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT, AND PROSTHETIC DEVICES (ACUTE CARE SERVICES)

REVISION DATE: 3/25/2016, 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994
REFERENCES: §36-2907; Laws 2015, Chapter 264, Section 3 (HB 2373); §36-2907.

A. Medical supplies, durable medical equipment (DME) orthotic and prosthetic devices provided to members who are eligible for Arizona Long Term Care System (ALTCS) services qualify as covered services if prescribed by a, specialist physician, practitioner or dentist upon referral by a Primary Care Provider (PCP). Medical supplies and DME include:

1. Surgical dressings, splints, casts, and other disposable items covered by Medicare (Title XVIII).

2. Rental or purchase of DME, including, customized equipment.

3. Other items as determined medically necessary by joint consultation of the Medical Directors of the health plan and the Division.

B. Requirements for specific services:

1. Incontinence Briefs

a. Incontinence briefs for members over the Age of 21 Years:

i. The Division's acute care contracted health plans shall provide incontinence briefs, including pull-ups, for members 21 years of age and older to treat a medical condition or to prevent skin breakdown when all the following are met:

- The member is incontinent due to a documented medical condition that causes incontinence of bowel and/or bladder.

- The Primary Care Provider (PCP) or attending physician has issued a prescription ordering the incontinence briefs.

- Incontinence briefs do not exceed 180 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 180 briefs per month.

- The member obtains incontinence briefs from vendors within the Contractor's network.

- Prior authorization has been obtained if required by the Administration, Contractor, or Contractor's designee, as appropriate. Contractors shall not require a new prior authorization to be issued more frequently than every 12 months.

ii. Authorized services must be for at least a 12 month period of time.

iii. Contractors may require a new prior authorization to be issued no more frequently than every 12 months.

iv. Payments for the use of incontinence briefs for the convenience of caregivers will not be authorized.

v. If a member is eligible for Fee-For-Service coverage, the Health Care Services Unit will prior authorize using the same criteria outlined above. Health Care Services Prior Authorization can be contacted by calling 602-771-8080.

vi. Any exceptions to this policy section must have the approval of the Assistant Director.

b. Incontinence briefs for members over three and under the Age of 21 Years:

Incontinence briefs are covered for members when necessary to treat a medical condition and/or for preventative purposes. For information on coverage and limitations see the *Division Medical Policy Manual Chapter 400, Section 430*.

2. DME means sturdy, long lasting items and appliances that can withstand repeated use, are designed to serve a medical purpose and are not generally useful to a person in absence of a medical condition, illness or injury.

Experience has demonstrated that the cost-effective provision of Durable Medical Equipment (DME) includes the involvement of a physical therapist in ordering and fitting customized equipment.

Documentation from therapists who have treated the member may be required. That documentation must establish the need for equipment and a comprehensive explanation of how the member will benefit from the equipment.

a. Orthotics- A device prescribed by a physical or other licensed practitioner to support a weak, injured, or deformed portion of the body.

i. Members 21 years of age and older:

Orthotics are covered within certain limitations if all of the following apply:

- The use of the orthotic is medically necessary as the preferred treatment option consistent with Medicare Guidelines.
- The orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition.
- The orthotic is ordered by a Physician or Primary Care Practitioner.

ii. Members under 21 years of age:

Orthotics are covered for members under the age of 21 as outlined in the *Division Medical Policy Manual Chapter 400 Section 430-C*.

iii. Orthotics Limitations- Reasonable repairs or adjustments of purchased orthotics are covered for all members to make the orthotic serviceable and/or when the repair cost is less than purchasing another unit. The component will be replaced if, at the time authorization is sought, documentation is provided to establish that the component is not operating effectively.

310-S OBSERVATION SERVICES

EFFECTIVE DATE: March 3, 2017

The Division of Developmental Disabilities (Division) covers Observations services. Observation services are those reasonable and necessary services provided on a hospital's premises for evaluation to determine whether the member should be admitted for inpatient care, discharged, or transferred to another facility. Observation services include: the use of a bed, periodic monitoring by a hospital's nursing or, if appropriate, other staff necessary to evaluate, stabilize or treat medical conditions of a significant degree of instability and/or disability on an outpatient basis.

It is not Observation when a member with a known diagnosis enters a hospital for a scheduled procedure/treatment that is expected to keep the member in the hospital for less than 24 hours (this is an outpatient procedure, regardless of the hour in which the member presented to the hospital, whether a bed was utilized, or whether services were rendered after midnight).

Extended stays after outpatient surgery must be billed as recovery room extensions.

Observation must be ordered in writing by a physician, or other individual authorized by hospital staff bylaws, in order to admit patients to the hospital or to order outpatient diagnostic tests or treatments. There is no maximum time limit for Observation services as long as medical necessity exists. The medical record must document the basis for Observation services.

Factors That Must Be Considered by the Physician or Authorized Individual When Ordering Observation

The following factors must be considered by the physician or authorized individual when ordering Observation:

A. Severity of the signs and symptoms of the member

B. Degree of medical uncertainty that the member may experience an adverse occurrence

C. Need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the member to remain at the hospital for 24 hours or more) to assist in assessing whether the member should be admitted

D. The availability of diagnostic procedures at the time and location where the member presents

E. It is reasonable, cost effective and medically necessary to evaluate a medical condition or to determine the need for inpatient admission

F. Length of stay for Observation is medically necessary for the member's condition.

Required Medical Record Documentation

The following are requirements for documenting medical records:

A. Orders for Observation must be written on the physician's order sheet, not the emergency room record, and must specify, "Observation." Rubber-stamped orders are not acceptable.

B. Follow-up orders must be written within the first 24 hours, and at least every 24 hours if Observation is extended.

C. Changes from "Observation to inpatient" or "inpatient to Observation" must be made per physician order.

D. Inpatient/outpatient status change must be supported by medical documentation.

Limitations

The following services are not Division-covered Observation services:

A. Substitution of Observation services for physician ordered inpatient services

B. Services that are not reasonable, cost effective and necessary for diagnosis or treatment of member

C. Services provided solely for the convenience of the member or physician

D. Excessive time and/or amount of services medically required by the condition of the member

E. Services customarily provided in a hospital-based outpatient surgery center and not supported by medical documentation of the need for Observation.

310-T PHYSICIAN SERVICES

EFFECTIVE DATE: March 3, 2017

REFERENCES: Division Medical Policy Manual Policies 310-N, 310-V, 320-M, and 400.

The Division of Developmental Disabilities (Division) covers physician services for all members eligible for ALTCS within certain limits based on member age and eligibility. Physician services include medical assessment, treatment, and surgical services performed in the office, clinic, hospital, home, nursing facility, or other location by a licensed doctor of medicine or osteopathy.

Physician services are covered as appropriate to the member's medical need and the physician's scope of practice. Refer to Chapter 400 of this Policy Manual, for criteria related to covered services for members under the age of 21.

Physical examinations and well visits for members are covered to:

A. Determine risk of disease.

B. Provide early detection.

C. Establish a prevention or treatment plan.

D. Monitor health status.

Limitations

A. Services Not Directly Related to Medical Care - The Division does not cover physician services routinely performed and not directly related to the medical care of a member (e.g., physician visits to a nursing facility for the purpose of 30-60 day certification).

B. Moderate Sedation - The Division does not cover moderate sedation (i.e., conscious sedation) performed by the physician performing the underlying procedure for which sedation is desired, or by another provider except as described below, for the adult population.

   The Division does cover monitored anesthesia care, including all levels of sedation, provided by qualified anesthesia personnel (physician anesthesiologist or certified registered nurse anesthetist) for the adult population and members under the age of 21. Anesthesia services (except epidurals) require the continuous presence of the anesthesiologist or certified registered nurse anesthetist.

C. Allergy Immunotherapy – The Division does not cover allergy immunotherapy including desensitization treatments administered via subcutaneous injections (allergy shots), sublingual immunotherapy (SLIT) or via other routes of administration, for persons age 21 years and older. However, the Division covers allergy immunotherapy for members under the age of 21 who are under Early Periodic Screening, Diagnosis and Treatment (EPSDT), when medically necessary.

Exceptions

A. Allergy Testing – The Division does not cover allergy testing, including testing for common allergens, for persons age 21 years and older *unless* the member has either sustained an anaphylactic reaction to an unknown allergen or has exhibited such a severe allergic reaction (e.g., severe facial swelling, breathing difficulties, epiglottal swelling, extensive [not localized] urticaria) where it is reasonable to assume further exposure to the unknown allergen may result in a life-threatening situation. In the above instances, the Division covers allergy testing to identify the unknown allergen where such identification may help the member avoid repeat exposures to that particular allergen. The Division covers allergy testing for persons under the age of 21 under EPSDT when medically necessary.

B. Self-administered epinephrine – The Division covers self-administered epinephrine for all members with a history of previous severe allergic reactions, whether or not the specific cause of that reaction has been identified.

For prescription medication coverage exceptions, refer to Policy 310-V in the Policy Manual.

C. Medical Marijuana – The Division does not cover office visits or any other services that are primarily for determining whether a member would benefit from medical marijuana. Refer to Policy 320-M in this Policy Manual.

Genetic Subspecialists

Genetic subspecialists are subject to the limitations described in Policy 310-N, Genetic Testing Provisions subsection in this Policy Manual.

310-U FOOT AND ANKLE SERVICES

REVISION DATE: 11/17/2017, 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994

The Division of Developmental Disabilities (Division) covers medically necessary foot and ankle care, including reconstructive surgeries, when ordered by a member's primary care provider, attending physician or practitioner, within certain limits.

Routine Foot Care includes services performed in the absence of localized illness, injury, or symptoms involving the foot. The Division considers routine foot care to be medically necessary in limited circumstances as described in this Policy. These services include:

A. The cutting or removal of corns or calluses

B. The trimming of nails (including mycotic nails)

C. Other hygienic and preventive maintenance care in the realm of self-care (such as cleaning and soaking the feet, and the use of skin creams to maintain skin tone of both ambulatory and bedfast patients).

Coverage includes medically necessary foot and ankle care such as wound care and treatment of pressure ulcers. Foot and ankle care also includes fracture care, reconstructive surgeries, and limited bunionectomy services.

The Division considers routine foot care to be medically necessary when the member has a systemic disease of sufficient severity that performance of foot care procedures by a nonprofessional person would be hazardous. Conditions that might require medically necessary foot care include metabolic, neurological, and peripheral vascular systemic diseases. Examples include, but are not limited to:

A. Arteriosclerosis obliterans (arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)

B. Buerger's disease (thromboangiitis obliterans)

C. Chronic thrombophlebitis

D. Diabetes mellitus

E. Peripheral neuropathies involving the feet

F. Chemotherapy being received by member

G. Pernicious anemia

H. Hereditary disorder, i.e., hereditary sensory radicular neuropathy

I. Fabry disease

J. Hansen's disease

K. Neurosyphilis

L. Malabsorption syndrome

M. Multiple sclerosis

N. Traumatic injury

O. Uremia (chronic renal disease)

P. Anticoagulation therapy.

The Division considers treatment of a fungal (mycotic) infection to be medically necessary foot care and covers it in the following circumstances:

A. A systemic condition

B. Clinical evidence of mycosis of the toenail

C. Compelling medical evidence documenting the member either:

1. Has a marked limitation of ambulation due to the mycosis which requires active treatment of the foot, or

2. In the case of a member who is non-ambulatory, has a condition that is likely to result in significant medical complications in the absence of such treatment.

Limitations

A. Coverage for medically necessary routine foot care must not exceed two visits per quarter or eight visits per contract year (this does not apply to members under age 21).

B. Coverage of mycotic nail treatments will not exceed one bilateral mycotic nail treatment (up to ten nails) per 60 days (this does not apply to members under age 21 eligible).

C. The following are diagnoses under which routine foot care is not covered:

- General diagnoses such as arteriosclerotic heart disease, circulatory problems, vascular disease, venous insufficiency
- Incapacitating injuries or illnesses such as rheumatoid arthritis, cerebral vascular accident (CVA, a.k.a. stroke) or fractured hip.

D. Services are not covered for members 21 years of age or older, when provided by a podiatrist or podiatric surgeon.

E. Bunionectomy

1. Bunionectomies are covered only when the bunion is present with:

   a. Overlying skin ulceration, or

   b. Neuroma secondary to bunion (neuroma to be removed at same surgery and documented by pathology report).

2. Bunionectomies are not covered, if the sole indications are pain and difficulty finding appropriate shoes.

310-V PRESCRIPTION MEDICATION/PHARMACY SERVICES

REVISION DATE: 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994

Pharmaceutical services include medically necessary drugs prescribed by Primary Care Provider (PCP), other physicians, practitioners, or dentists upon referral by a PCP Psychotropic drugs for the control of seizures and spasticity shall be covered, as well as vaccines used to prevent Hepatitis B. At a minimum, items listed in the Division's Formulary shall be included as covered benefits for members who are eligible for Arizona Long Term Care System (ALTCS) services.

Psychotropic drugs for behavioral health symptoms shall be covered according to the Arizona Health Care Cost Containment System (AHCCCS) Rules.

Prescriptions shall be dispensed with a 30-day supply of medication, if authorized by the prescriber.

Pharmaceutical services shall be available to members during customary business hours and shall be located within reasonable travel distance.

310-W RADIOLOGY AND MEDICAL IMAGING

EFFECTIVE DATE: March 3, 2017

REFERENCES: A.A.C. R9-22-201, et seq.

The Division of Developmental Disabilities covers all radiology and medical imaging services for all members eligible for AHCCCS when ordered by a primary care provider, other practitioner, or dentist, for diagnosis, prevention, treatment or assessment of a medical condition, as defined in 9 A.A.C. Chapter 22, Article 2. Settings for the provision of services include hospitals, clinics, physician offices, and other health care facilities.

310-X REHABILITATIVE THERAPY

REVISION DATE: 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994

Rehabilitation is the process of re-establishing former functions or skills. This includes physical, occupational, and speech therapies. This service may occur after a trauma has decreased the functioning of a member. Rehabilitative therapies are not designed to build a skill or functioning level that had not been previously present in the member.

310–Y RESPIRATORY THERAPY

EFFECTIVE DATE: March 3, 2017
REFERENCES: A.R.S. § 32-3501

The Division of Developmental Disabilities (Division) covers respiratory therapy treatment service for members eligible for ALTCS, when ordered by a primary care provider, to restore, maintain, or improve respiratory functioning.

Services include:

A. Administering pharmacological, diagnostic, and therapeutic agents related to respiratory and inhalation care procedures

B. Observing and monitoring signs and symptoms

C. General behavioral and physical response(s) to respiratory treatment and diagnostic testing, including a determination of whether these signs, symptoms, reactions, or response(s) exhibit abnormal characteristics

D. Implementing appropriate reporting referral

E. Implementing respiratory care protocols or changes in treatment based on observed abnormalities.

The Division covers medically necessary respiratory therapy services for all members eligible for ALTCS on both an inpatient and outpatient basis. Services must be provided by a qualified respiratory practitioner under A.R.S. § 32-3501 (respiratory therapist or respiratory therapy technician), licensed by the Arizona Board of Respiratory Care Examiners. Respiratory practitioners providing services to Division members outside the State of Arizona must meet the applicable state and/or federal requirements.

310–AA TOTAL PARENTERAL NUTRITION (TPN)

EFFECTIVE DATE: November 17, 2017

Total Parenteral Nutrition (TPN) is the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength appropriate for the individual's general condition. Nutrients are provided through an indwelling intravenous catheter.

The Division of Developmental Disabilities (Division) follows Medicare guidelines for the provision of TPN services. TPN is covered for members over age 21 when it is medically necessary and the only method to maintain adequate weight and strength.

The Division covers TPN for members receiving Early and Periodic Screening, Diagnosis and Treatment, also known as "EPSDT," when medically necessary.

310-BB TRANSPORTATION

REVISION DATE: 11/17/2017, 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994
REFERENCES: A.R.S. § 28-2515; A.A.C. R9-22-211

The Division of Developmental Disabilities (Division) covers transportation within certain limitations for members. Covered transportation services include:

A. Emergency transportation

B. Medically necessary non-emergency transportation

C. Medically necessary maternal and newborn transportation.

Definitions

The definitions relating to covered transportation services are as follows:

A. Air ambulance - helicopter or fixed wing aircraft licensed under Arizona Department of Health Services (ADHS) as mandated by Arizona Revised Statutes to be used in the event of an emergency to transport members or to obtain services.

B. Ambulance - motor vehicle licensed by ADHS pursuant to Arizona Revised Statutes especially designed or constructed, equipped and intended to be used, maintained, and operated for the transportation of persons requiring ambulance services.

C. Ambulatory vehicle – a vehicle other than a taxi but includes vans, cars, minibus or mountain area transport. The member must be able to transfer with or without assistance into the vehicle and not require specialized transportation modes.

D. Stretcher van – vehicle specifically designed for the purpose of transportation of a member on a medically approved stretcher device. The stretcher must be secured to avoid injury to the member or other passengers. Safety features of stretcher vans must be maintained as necessary. Any additional items being transported must also be secured for safety. The member must need to be transported by stretcher and must be physically unable to sit or stand and any other means of transportation is medically contraindicated.

E. Wheelchair van - vehicle specifically equipped for the transportation of an individual seated in a wheelchair. Doors of the vehicle must be wide enough to accommodate loading and unloading of a wheelchair. Wheelchair vans must include electronic lifts for loading and unloading wheelchair bound transports. The vehicle must contain restraints for securing wheelchairs during transit. Safety features of wheelchair vans must be maintained as necessary. Any additional items being transported must also be secured for safety. The member must require transportation by wheelchair and must be physically unable to use other modes of ambulatory transportation.

F. Taxi – vehicle that has been issued and displays a special taxi license plate pursuant to A.R.S. § 28-2515.

Emergency Transportation

Emergency Transportation - emergency ground and air ambulance services required to manage an emergency medical condition of a member at an emergency scene and transport to the nearest appropriate facility are covered for all members. Emergency transportation is needed due to a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could be expected to result in:

A. Placing the member's health in serious jeopardy

B. Serious impairment of bodily functions, or

C. Serious dysfunction of any bodily organ or part.

Emergency transportation may be initiated by an emergency response system call "9-1-1," fire, police, or other locally established system for medical emergency calls. Initiation of a designated emergency response system call by a member automatically dispatches emergency ambulance and Emergency Medical Technician (EMT) or Paramedic team services from the Fire Department. At the time of the call, emergency teams are required to respond; however, when they arrive on the scene, the services required at that time (based on field evaluation by the emergency team) may be determined to be:

A. Emergent

B. Non-emergent, but medically necessary, or

C. Not medically necessary.

Maternal and Newborn Transportation - The Maternal Transport Program (MTP) and the Newborn Intensive Care Program (NICP) administered by the ADHS provides special training and education to designated staff in the care of maternity and newborn emergencies during transport to a perinatal center. The high risk transport team is dispatched after consultation with the MTP or NICP perinatologist or neonatologist. Only MTP or NICP Contractors may provide air transport.

Emergency transportation coverage is limited to those emergencies in which specially staffed and equipped ambulance transportation is required to safely manage the member's medical condition. Basic Life Support, Advanced Life Support, and air ambulance services are covered, depending upon the member's medical needs.

Emergency medical transportation includes the transportation of a member to a higher level of care for immediate medically necessary treatment, even after stabilization at an emergency facility. Emergency medical transportation is covered only to the nearest appropriate facility. The Division and Administrative Services Subcontractors (AdSSs) may establish preferred hospital arrangements, which must be communicated with emergency services providers. If the provider transports the member to the preferred hospital, the provider’s claim must be honored even though that hospital may not be the nearest appropriate facility. However, the provider must not be penalized for taking the member to the nearest appropriate facility whether or not it is the preferred facility.

Acute conditions requiring emergency transportation to obtain immediate treatment include, but are not limited to, the following:

A. Untreated fracture or suspected fracture of spine or long bones

B. Severe head injury or coma

C. Serious abdominal or chest injury

D. Severe hemorrhage

E. Serious complications of pregnancy

F. Shock, heart attack or suspected heart attack, stroke or unconsciousness

G. Uncontrolled seizures

H. Condition warranting use of restraints to safely transport to medical care.

For utilization review, the test for appropriateness of the request for emergency services is whether a prudent layperson, if in a similar situation, would have requested such services. Determination of whether a transport is an emergency is based on the member's medical condition at the time of transport.

Refer to the section of this policy regarding medically necessary transportation furnished by an ambulance provider, for information related to transportation initiated by an emergency response system call.

Air ambulance services are covered under any of the following conditions:

A. The point of pickup is inaccessible by ground ambulance

B. Great distances or other obstacles are involved in getting the member to the nearest hospital with appropriate facilities

C. The medical condition of the member requires ambulance service, and ground ambulance services will not suffice.

Air ambulance vehicles must meet ADHS licensing requirements and requirements set forth by the Federal Aviation Administration. Air ambulance companies must be licensed by the ADHS and be registered as a provider with AHCCCS.

Emergency Transportation Provider Requirements for Emergency Transportation Services Provided for Division Fee-For-Service, American Indian Health Plan

Emergency Transportation Services - In addition to other requirements specified in this policy, emergency transportation providers rendering services on an American Indian Reservation must meet the following requirements:

A. Tribal emergency transportation providers must be certified by the Tribe and Center for Medicare and Medicaid Services (CMS) as a qualified provider and registered as an AHCCCS provider.

B. If non-tribal emergency transportation providers render services under a contract with a Tribe either on-reservation or to and from an off-reservation location the provider must be State licensed and certified, and registered as an AHCCCS provider, or

C. Non-tribal transportation providers not under contract with a Tribe must meet requirements specified in this policy for emergency transport providers.

As with all emergency transportation, services are covered to manage an emergency medical condition at the emergency scene and in transport to the nearest appropriate facility.

Medically Necessary Non-Emergency Transportation Furnished by Non-Emergency Transportation Providers for Medical and Behavioral Health Services

Non-emergency medically necessary transportation is transportation, as specified in A.A.C. R9-22-211, and furnished by providers included therein, to transport the member to and from a covered medical service. Such services may also be provided by emergency transportation providers after assessment by the EMT or Paramedic team that the member's condition requires medically necessary transportation.

Medically necessary non-emergency transportation services are covered under the following conditions:

A. The medical or behavioral health service for which the transportation is needed is a covered Division service.

B. The member is not able to provide, secure, or pay for their own transportation, and free transportation is not available, and

C. The transportation is provided to and from the nearest appropriate AHCCCS-registered provider.

Medically Necessary Non-Emergency Transportation Furnished by Non-Ambulance Providers

The following must be adhered to:

A. The member must not require medical care enroute.

B. Passenger occupancy must not exceed the manufacturer's specified seating occupancy.

C. Members, escorts, and other passengers must follow state laws regarding passenger restraints for adults and children.

D. Vehicle must be driven by a licensed driver, following applicable State laws.

E. Vehicles must be insured.

F. Vehicles must be in good working order.

G. Members must be transported inside the vehicle.

H. School-based providers should follow the school-based policies in effect (AMPM Chapter 700).

Medically Necessary Non-Emergency Transportation Furnished By Ambulance Providers

Medically necessary non-emergency transportation furnished by ambulance providers is appropriate if:

A. Documentation that other methods of transportation are contraindicated, and

B. The member's medical condition, regardless of bed confinement, requires the medical treatment provided by the qualified staff in an ambulance.

For hospital patients only:

Round-trip air or ground transportation services may be covered if a member who is inpatient goes to another facility to obtain necessary specialized diagnostic and/or therapeutic services (such as a computerized tomography ("CT") scan or cobalt therapy). Such transportation may be covered if services are not available in the hospital in which the member is inpatient.

Transportation services to the nearest medical facility that can render appropriate services are also covered, when the transport was initiated through an emergency response system call and, upon examination by emergency medical personnel, the member's condition is determined to be non-emergent but one which requires medically necessary transportation. At the Division's or AdSS's discretion, medically necessary non-emergency ambulance transportation may not require prior authorization or notification, but it is subject to review for medical necessity. Medical necessity criteria are based upon the medical condition of the member and include ground ambulance services provided because the member's medical condition was contradictory to any other means of transportation. This may include after-hour calls.

310-DD ORGAN TRANSPLANT

REVISION DATE: 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994

Organ transplant services and procurement shall be in accordance with Arizona Health Cost Containment System (AHCCCS) Rules (www.azhcccs.gov/Regulations). Organ transplant services also require written prior authorization from the Division of Developmental Disabilities (DDD) and AHCCCS.

320-A AFFILIATED PRACTICE DENTAL HYGIENIST

EFFECTIVE DATE: March 3, 2017
REFERENCES: Division Medical Policy 430, A.R.S. §§ 32-1281 and 32-1289.

The Division of Developmental Disabilities (Division) covers oral health care services as described in this Policy Manual Chapter 400, Policy 430, Early Periodic Screening, Diagnosis and Treatment Services. As allowed by State law, A.R.S. §§ 32-1281 and 32-1289, and described in this policy, dental hygienists with an affiliated practice agreement may provide dental hygiene services to members eligible for ALTCS and Targeted Programs who are 18 years of age and younger.

The Division covers dental hygiene services provided by Arizona-licensed dental hygienists subject to the terms of the written affiliated practice agreement entered into between a dentist and a dental hygienist.

Each affiliated dental hygienist, when practicing under an affiliated practice relationship, may perform only those duties specified within the terms of the affiliated practice relationship and they must maintain an appropriate level of contact, communication, and consultation with the affiliated practice dentist.

In addition to the requirements specified in A.R.S. §§ 32-1281 and 32-1289, the following are required:

A. Both the dental hygienist and the dentist in the affiliated practice relationship must be registered AHCCCS providers.

B. The affiliated practice dental hygienist must maintain individual medical records in accordance with the Arizona State Dental Practice Act. At a minimum, this must include member identification, parent/guardian identification, signed authorization (parental consent) for services, member medical history, and documentation of services rendered.

C. The affiliated practice dental hygienist must register with AHCCCS and bill for services under their individual AHCCCS provider identification number/National Provider Identifier (NPI) number.

D. The affiliated practice dental hygienist will only be reimbursed for providing services in accordance with State regulations, Division and AHCCCS policy, the AHCCCS provider agreement, and their affiliated practice agreement.

Reimbursement for dental radiographs is restricted to providers who are qualified to perform both the exposure and the interpretation of dental radiographs.

320-E HEALTH AND BEHAVIOR INTERVENTION

REVISION DATE: 11/17/2017
EFFECTIVE DATE: May 13, 2016

Health and behavioral assessment procedures (CPT codes 96150-96155) are used to identify and treat the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, and management of physical health problems. The focus of the assessment is not on mental health, but on the stresses, expectations, lifestyle, and perceptions that are associated with the underlying medical condition. Codes 96150 - 96155 describe services offered to members who present with primary physical illnesses, diagnosis, or symptoms and may benefit from assessments and interventions that focus on the biopsychosocial factors related to the member's health. These services do not represent preventative medicine counseling and risk factor reduction interventions. Therefore, evaluation and management services codes (including preventative medicine, individual counseling codes 99401-99404 and preventative medicine, group counseling codes 99411-99412) should not be reported on the same day.

The Division of Developmental Disabilities covers medically necessary health and behavioral assessment procedures (CPT codes 96150-96155). The focus of the assessment/ interventions is not on mental health but the biopsychosocial factors important to physical health problems and treatment. The focus of the intervention is to improve the member's health and well-being, using cognitive, behavioral, social, and/or psychophysiological procedures designed to ameliorate specific disease-related problems.

Individuals requiring the service(s) described above must not be referred to a Behavioral Health Provider.

Codes

A. 96150- Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment.

B. 96151 - Re-assessment

C. 96152 - Health and behavior intervention, each 15 minutes, face-to-face; individual

D. 96153 - Group (two or more patients)

E. 96154 - Family (with the patient present)

F. 96155 - Family (without the patient present)

The following professionals are approved to provide health and behavioral assessments/ interventions:

A. Psychologist

B. Licensed clinical social worker

C. Licensed marriage and family therapist

D. Licensed professional counselor

E. Psychiatric nurse practitioner.

Health and behavior intervention services may be performed in the following places of service:

A. Federally Qualified Health Clinic (FQHC)

B. Rural Health Clinic

C. Provider Office

D. The member's home

E. Indian Health Service (IHS) Freestanding Facility

F. IHS Provider Based Facility

G. Tribal 638 Freestanding Facility

H. Tribal 638 Provider Based Facility

I. Integrated Behavioral Health Residential Facility.

Limitations

A. Services are limited to 48 units annually (unit is equal to 15 minutes).

B. Members with mental health treatment needs exceeding the scope or duration of services described (which are medical codes for behavioral health interventions) should be appropriately referred for behavioral health services that will require the specific use of behavioral health codes.

C. Services are limited to the providers and settings listed above.

320-F HIV/AIDS TREATMENT SERVICES

EFFECTIVE DATE: November 17, 2017
REFERENCES: A.A.C. R4-16-101

The Division of Developmental Disabilities (Division) covers medically necessary treatment services rendered by qualified providers, for members who are eligible for the Division, ALTCS, or American Indian Health Plan (AIHP), and who have been diagnosed with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS). The Division and the Administrative Services Subcontractors (AdSS) must follow the Centers for Disease Control and Prevention (CDC) guidelines for the treatment of HIV/AIDS. The Division and the Administrative Services Subcontractors are responsible for distributing these guidelines, and all updates, to HIV/AIDS treatment professionals included in their network.

As appropriate, AHCCCS reviews new technological advances in HIV/AIDS treatment, including recommended pharmacological regimens.

This review shall include the AHCCCS Chief Medical Officer, the AHCCCS Medical Director, the Division Medical Director, the Administrative Services Medical Director, and physician experts in the treatment of HIV/AIDS.

The review may include, but is not limited to, information regarding:

A. Established treatment and pharmaceutical regimens

B. Changes in technology and treatment protocols

C. Cost implications of treatment/pharmaceutical regimens.

Monitoring

The Division and the AdSS must develop policies and protocols that document care coordination services provided to members with HIV/AIDS. This includes monitoring of member medical care in order to ensure that medical services, medication regimens, and necessary support services (e.g., transportation) are provided within specified timelines, as defined in contractual arrangements with the Division, and that these services are used appropriately. Support services may be coordinated with existing community resources.

The AdSS must also ensure that the care for members diagnosed with HIV/AIDS, who are receiving services specified by, and in accordance with, the guidelines set by AHCCCS, is well coordinated and managed in collaboration with the member‘s treating physician.

If a conflict regarding treatment or denial of treatment arises between the member‘s treating physician and the Division’s Medical Director, the issue may be referred to the AHCCCS Medical Director or designee. However, this does not preclude the member‘s right to file an appeal.

HIV/AIDS Treatment Professionals

AHCCCS compiles, updates, and makes available, upon request, a listing of qualified HIV/AIDS treatment professionals (physicians, nurse practitioners, and/or physician assistants). The listing will be based on information submitted by the Division as specified in contractor reporting requirements.

A qualified HIV/AIDS treatment professional, for the purpose of this policy, is defined as a physician or practitioner who:

A. Is recognized in the community as having a special interest, knowledge, and experience, in the treatment of HIV/AIDS

B. Agrees to adhere to CDC treatment guidelines for HIV/AIDS

C. Agrees to provide primary care services and/or specialty care to AHCCCS members with HIV/AIDS

D. Demonstrates ongoing professional development by clinically managing at least five patients with HIV/AIDS during the last year

E. Meets one of the criteria below:

   1. Current Board Certification or Recertification in Infectious Diseases, or

   2. Annual completion of at least ten hours of HIV/AIDS-related Continuing Medical Education (CME), which meet the CME requirements under A.A.C. R4-16-101.

Limitations

A physician or practitioner not meeting the criteria to be a qualified HIV/AIDS treatment professional who wishes to provide primary care services to a member with HIV/AIDS must send documentation to the Division or AdSS demonstrating that s/he has an established consultative relationship with a physician who meets the criteria for a qualified HIV/AIDS treatment professional as identified in this policy.

This documentation must be maintained in the Division and AdSS' credentialing file. These practitioners may treat members with HIV/AIDS under the following circumstances:

A. In geographic areas where the incidence of members with HIV/AIDS is low, and/or where there are no available AHCCCS-registered network HIV/AIDS treatment professionals meeting this criteria, or

B. When a member with HIV/AIDS chooses a provider who does not meet the criteria.

Contract Network

The Division and the AdSS must include in its individual provider network sufficient numbers of qualified HIV/AIDS treatment professionals (physicians, nurse practitioners and/or physician assistants). The AdSS must also have policies and procedures to assure that provider requirements and standards specified in the Division Policy Manuals and the AMPM are met. Each provider network of HIV/AIDS treatment professionals is subject to review and approval by AHCCCS, Division of Health Care Management (DHCM). The AdSS must submit, annually by December 15, a list of HIV/AIDS treatment providers (to the Division Health Care Services Unit, through the Compliance Unit) that includes:

A. Name and location of all qualified HIV/AIDS treatment professionals treating members with HIV/AIDS

B. For each Primary Care Provider (PCP) treating members with HIV/AIDS who is not a qualified HIV/AIDS treatment specialist, the name and location of the consulting HIV/AIDS treatment professional.

The AdSS must also notify the Division of any material change to the HIV/AIDS provider network during the year. The Division will notify AHCCCS of any major changes.

AdSS policies must reflect that members with HIV/AIDS have freedom of choice to select an HIV/AIDS provider from the AdSS's network. If the member selects a PCP in the AdSS's network who is not a provider designated by the AdSS as a qualified HIV/AIDS disease treatment professional, the member must be informed that only those designated providers are authorized to render treatment regimens such as antiretroviral therapies. The selected PCP must consult with a qualified HIV/AIDS provider and follow the recommendations of the consultant in order for the treatment regimen (such as protease inhibitors) to be a covered service.

320-G LUNG VOLUME REDUCTION SURGERY

EFFECTIVE DATE: March 3, 2017

The Division of Developmental Disabilities (Division) covers Lung Volume Reduction Surgery (LVRS), or reduction pneumoplasty, for members eligible for ALTCS with severe emphysema. This surgery must be performed at a facility approved by Medicare in accordance with all of the established Medicare guidelines.

The member's treating physician is responsible for providing appropriate documentation, establishing medical necessity, and verification of compliance with Medicare, Division of Developmental Disabilities (Division), and AHCCCS guidelines. When requesting authorization, the documentation must be sent to the Division's Administrative Services Subcontractor (AdSS) Medical Director or to the Division's Medical Director for Division's American Indian Health Plan (AIHP) (Fee-For-Service) members.

When possible, such surgeries, and the required pre- and post-operative therapies, will be performed at facilities approved by Medicare for LVRS reimbursement within the State of Arizona. However, this procedure may be covered at out-of-state facilities, if needed. All facilities must meet Medicare LVRS facility requirements as well as AHCCCS Provider Registration requirements.

If medically necessary, the Division or AdSS may pay for an adult caregiver to accompany members when out-of-state-travel is required. Transportation, lodging, and board may be covered as appropriate.

Medicare Criteria

The Centers for Medicare and Medicaid Services (CMS) has issued a National Coverage Decision (NCD) for LVRS specifying covered and non-covered criteria. Medicare established guidelines are followed for this procedure according to the NCD effective 11/17/2005. NCD for LVRS is contained in Exhibit 320-1, as adopted by the Division for use, and found in the AHCCCS Medical Policy Manual.

320-H MEDICAL FOODS

EFFECTIVE DATE: May 13, 2016

Description of Benefit

The Division covers medical foods, within the limitations specified in this Policy, for any member diagnosed with one of the following inherited metabolic conditions:

A. Phenylketonuria

B. Homocystinuria

C. Maple Syrup Urine Disease

D. Galactosemia (requires soy formula)

E. Beta Keto-Thiolase Deficiency

F. Citrullinemia

G. Glutaric Acidemia Type I

H. 3 Methylcrotonyl CoA Carboxylase Deficiency

I. Isovaleric Acidemia

J. Methylmalonic Acidemia

K. Propionic Acidemia

L. Arginosuccinic Acidemia

M. Tyrosinemia Type I

N. HMG CoA Lyase Deficiency

O. Cobalamin A, B, C Deficiencies

Definitions

A. **Medical foods:** Metabolic formula or modified low-protein foods that are produced or manufactured specifically for persons with a qualifying metabolic disorder and that are not generally used by persons in the absence of a qualifying metabolic disorder. Soy formula is also included within the limitations set by this Policy when used by persons diagnosed with galactosemia.

B. **Metabolic nutritionist:** A provider registered with the Arizona Health Care Cost Containment System (AHCCCS) who is a registered dietitian specializing in nutritional assessment and treatment of metabolic conditions.

Conditions, Limitations and Exclusions

A. The diagnosis of the member's inherited metabolic condition is documented in the member's medical record by the Primary Care Provider (PCP), attending physician or appropriate specialist. Documentation also includes test results used in establishing the diagnosis.

B. Metabolic formula and modified low-protein foods must be:

1. Essential to sustain the member's growth within nationally recognized height/weight or BMI (body mass index) levels, maintain health and support metabolic balance;

2. Obtained only under physician order; and

3. Supervised by the member's PCP, attending physician or appropriate specialist for the medical and nutritional management of a member who has:

a. Limited capacity to metabolize typical foods or certain nutrients contained in typical food; or

b. Other specific nutrient requirements as established by medical evaluation.

C. Metabolic formulas ordered for a member must be processed for the specific dietary management of the member's metabolic condition. The formula must meet the member's distinctive nutritional requirements that are established through medical evaluations by the member's PCP, attending physician or appropriate specialist, and/or the metabolic nutritionist.

D. Modified low-protein foods must be formulated to contain less than one gram of protein per unit or serving. For purposes of this Policy, modified low-protein foods do not include foods that are naturally low in protein.

E. Soy formula is covered only for members receiving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, who are diagnosed with galactosemia, only until they are able to eat solid lactose-free foods.

F. Members receiving EPSDT services, who are diagnosed with a metabolic disorder included in this Policy, are eligible for services through Children's Rehabilitation Services (CRS).

1. Members receiving EPSDT services must receive metabolic formula through CRS.

2. Members receiving EPSDT services who require modified low-protein foods receive them through the Division.

G. The Division provides both necessary metabolic formula and modified low protein foods for members 21 years of age and older who have been diagnosed with one of the inherited metabolic disorders included in this Policy.

H. The Division is responsible for initial and follow-up consultations by a genetics physician and/or a metabolic nutritionist, lab tests and other services related to the provision of medical foods for enrolled members diagnosed with a metabolic disorder included in this Policy.

I. Medical foods must be ordered from a supplier of metabolic formula, modified low-protein foods or soy formula that is approved by the Division. Foods purchased through grocery or health food stores are not covered.

320-I TELEHEALTH AND TELEMEDICINE

REVISION DATE: 11/17/2017
EFFECTIVE DATE: May 13, 2016
REFERENCES: AMPM Policy 431; Social Security Act, Section 1905(a)

The Division of Developmental Disabilities (Division) covers medically necessary consultative and/or treatment telemedicine services for all members eligible for AHCCCS, when these services are provided by an appropriate AHCCCS-registered provider.

Definitions

A. Asynchronous or "Store and Forward" - the transfer of data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation. Asynchronous or "store and forward" applications would not be considered telemedicine but may be utilized to deliver services.

B. Consulting Provider - any AHCCCS-registered provider who is not located at the originating site who provides an expert opinion to assist in the diagnosis or treatment of a member.

C. Distant or Hub Site - the site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system.

D. Originating or Spoke Site - the location of the patient at the time the service being furnished via a telecommunications system occurs. Telepresenters may be needed to facilitate the delivery of this service.

E. Telecommunications Technology (which includes store and forward) - the transfer of medical data from one site to another through the use of a camera, electronic data collection system such as an Electrocardiogram (ECG), or other similar device, that records (stores) an image which is then sent (forwarded) via telecommunication to another site for consultation. Services delivered using telecommunications technology, but not requiring the member to be present during their implementation, are not considered telemedicine. For information about coverage of these services, see Section titled Use of Telecommunications in this policy.

F. Teledentistry - the acquisition and transmission of all necessary subjective and objective diagnostic data through interactive audio, video or data communications by an AHCCCS-registered dental provider to a distant dentist for triage, dental treatment planning, and referral.

Teledentistry includes the provision of preventive and other approved therapeutic services by the AHCCCS-registered Affiliated Practice Dental Hygienist, who provides dental hygiene services under an affiliated practice relationship with a dentist.

Teledentistry does not replace the dental examination by the dentist; limited, periodic, and comprehensive examinations cannot be billed through the use of teledentistry alone.

G. Telehealth (or Telemonitoring) - use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance.

Telehealth includes such technologies as telephones, facsimile machines, electronic mail systems, and remote patient monitoring devices, which are used to collect and transmit patient data for monitoring and interpretation. While they do not meet the Medicaid definition of telemedicine they are often considered under the broad umbrella of telehealth services. Even though such technologies are not considered "telemedicine," they may nevertheless be covered and reimbursed as part of a Medicaid coverable service, such as laboratory service, x-ray service or physician services (under section 1905(a) of the Social Security Act).

H. Telemedicine - the practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data between the originating and distant sites through real time interactive audio, video or data communications that occur in the physical presence of the member.

I. Telepresenter - a designated individual who is familiar with the member's case and has been asked to present the member's case at the time of telehealth service delivery if the member's originating site provider is not present. The telepresenter must be familiar, but not necessarily the medical expert, with the member's medical condition in order to present the case accurately.

Use of Telemedicine

The Division covers the following medically necessary services provided via telemedicine. These services must be provided in real-time visits, the cost of which would otherwise be reimbursed by the Division.

A. Cardiology

B. Dermatology

C. Endocrinology

D. Hematology/oncology

E. Infectious diseases

F. Neurology

G. Obstetrics/gynecology

H. Oncology/radiation

I. Ophthalmology

J. Orthopedics

K. Pain clinic

L. Pathology

M. Pediatrics and pediatric subspecialties

N. Radiology

O. Rheumatology

P. Surgery follow-up and consultations

Q. Behavioral Health

R. Diagnostic consultation and evaluation, including:

1. Psychotropic medication adjustment and monitoring

2. Individual and family counseling

3. Case management.

Use of Telecommunications

Services delivered using telecommunications are generally not covered by the Division as a telemedicine service. The exceptions to this are described below:

A. A provider in the role of telepresenter may be providing a separately billable service under their scope of practice such as performing an ECG or an x-ray. In this case, that separately billable service would be covered, but the specific act of tele-presenting would not be covered.

B. A consulting provider at the distant site may offer a service that does not require real time interaction with the member. Reimbursement for this type of consultation is limited to dermatology, radiology, ophthalmology, and pathology and is subject to review by the Division.

C. In the special circumstance of the onset of acute stroke symptoms within three hours of presentation, the Division and AHCCCS recognize the critical need for a neurology consultation in rural areas to aid in the determination of suitability for thrombolytic administration. Therefore, when a member presents within three hours of onset of stroke symptoms, the Division will reimburse the consulting neurologist if the consult is placed for assistance in determining appropriateness of thrombolytic therapy even when the patients' condition is such that real-time video interaction cannot be achieved due to an effort to expedite care.

Use of Teledentistry Services

The Division covers teledentistry for members eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) when provided by an AHCCCS-registered dental provider. Refer to AMPM Policy 431 for more information on "Oral Health Care for EPSDT Aged Members."

Conditions, Limitations and Exclusions

A. Both the referring and consulting providers must be registered with AHCCCS.

B. A consulting service delivered via telemedicine by other than an Arizona-licensed provider must be provided by an AHCCCS-registered provider licensed to practice in the state or jurisdiction from which the consultation is provided. Consulting providers employed by an Indian Health Services (IHS), Tribal or Urban Indian Health Program, must be appropriately licensed based on IHS and 638 Tribal Facility requirements.

C. At the time of service delivery via real time telemedicine, the member's health care provider may designate a trained telepresenter to present the case to the consulting provider if the member's primary care provider or attending physician, or other medical professional who is familiar with the member's medical condition, is not present. The telepresenter must be familiar with the member's medical condition in order to present the case accurately. Medical questions may be submitted to the referring provider when necessary but no payment is made for such questions.

D. Nonemergency transportation to and from the telemedicine originating site to receive a medically necessary consultation or treatment service is covered.

320-K TOBACCO CESSATION PRODUCT POLICY

EFFECTIVE DATE: March 3, 2017

REFERENCES: AHCCCS Medical Policy Manual Exhibit 320-K-1

The Division of Developmental Disabilities (Division) covers tobacco cessation products, ordered by a Primary Care Provider (PCP), which include Nicotine Replacement Therapy (NRT) and tobacco use medications, for members who are eligible for the ALTCS who wish to stop using tobacco. The Division encourages members to enroll in a tobacco cessation program offered by the Arizona Department of Health Services (ADHS).

The following criteria apply to members choosing to receive a tobacco cessation product.

A. Members 18 years and older are encouraged to enroll in a tobacco cessation program through ADHS. To enroll in an ADHS cessation program the member must call 1-800-556-6222.

B. Members must contact their Primary Care Provider (PCP) for a prescription for a tobacco cessation product. The PCP will identify an appropriate tobacco cessation product. This includes all tobacco cessation products, including those that are available over-the-counter.

C. The maximum supply a member may receive of a tobacco cessation product is a 12-week supply in a six-month time period. The six-month period begins on the date the pharmacy fills the first tobacco cessation product.

D. The Division has adopted the prior authorization protocol described in AHCCCS Medical Policy Manual Exhibit 320-K-1, which must be followed by the Administrative Services Subcontractors.

320-M MEDICAL MARIJUANA

REVISION DATE: 4/17/2015
EFFECTIVE DATE: March 2, 2015

Medical marijuana is not a covered medical or pharmacy benefit. Office visits or any other services that are for the purpose of determining if a member would benefit from medical marijuana are also not covered. Under no circumstance shall any employee of the Department and any owner, director, principal, agent, employee, subcontractor, volunteer, and staff of the Division's service providers administer or store medical marijuana for Division members.

330 SERVICES FOR THE CHILDREN'S REHABILITATIVE SERVICES PROGRAM

REVISION DATE: 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994

Members eligible for Arizona Long Term Care System (ALTCS) may also be eligible for Children's Rehabilitative Services (CRS). Members eligible for the Division and CRS will receive CRS specialty services and behavioral health services through United Healthcare Community Plan or its successor. These members will continue to receive acute care services through their Division acute health plan.