Chapter 400 **Medical Policy for Maternal and Child Health**

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410 MATERNITY CARE SERVICES

REVISION DATE: 8/22/2018, 1/15/2016, 7/3/2015, 9/15/2014

EFFECTIVE DATE: June 30, 1994

REFERENCES: A.A.C. R9-16-111 through 113, A.R.S. § 14-5101; AMPM 400:410; AMPM Appendix F; AMPM Attachment 410-B, C, D, and E; AMPM Exhibit 400-2A; Contract Exhibit C Deliverables

Maternity care services are covered for all members of childbearing age, eligible for ALTCS and Targeted Support Coordination. Maternity care services include, but are not limited to, medically necessary preconception counseling, identification of pregnancy, medically necessary education and prenatal services for the care of pregnancy, the treatment of pregnancy-related conditions, labor and delivery services, and postpartum care. In addition, related services such as outreach and family planning services (see Division Medical Policy 420) are provided, whenever appropriate, based on the member's current eligibility and enrollment.

All maternity care services must be delivered by qualified physicians and non-physician practitioners, and they must be provided in compliance with the most current American Congress of Obstetricians and Gynecologists (ACOG) standards for obstetrical and gynecological services. Prenatal care, labor/delivery, and postpartum care services may be provided by licensed midwives, within their scope of practice, while adhering to AHCCCS risk-status consultation/referral requirements. According to ACOG guidelines, cesarean section deliveries must be medically necessary. Inductions and cesarean section deliveries prior to 39 weeks must be medically necessary. Cesarean sections and inductions performed prior to 39 weeks that are not found to be medically necessary based on nationally established criteria are not eligible for payment.

A. Requirements for Providing Maternity Care Services

The Division's Administrative Services Subcontractors (AdSSs) must establish and operate a maternity care program with program goals directed at achieving optimal birth outcomes. The minimum requirements of the maternity care program are:

1. Employment of sufficient numbers of appropriately qualified local personnel in order to meet the requirements of the maternity care program for eligible members and achieve contractual compliance.

2. Provision of written member educational outreach related to:

   a. Risks associated with elective inductions and cesarean sections prior to 39 weeks gestation

   b. Healthy pregnancy measures (e.g., addressing nutrition, sexually transmitted infections, substance abuse and other risky behaviors)

   c. Dangers of lead exposure to mother and baby during pregnancy

   d. Postpartum depression

e. Importance of timely prenatal and postpartum care

f. Other selected topics at a minimum of once every 12 months.

These topics may be addressed separately or combined into one written outreach material; however, each topic must be covered during the twelve-month period. The AdSS may use multiple different venues to meet these requirements.

3. Conducting of outreach and education activities to identify currently enrolled members who are pregnant, and enter them into prenatal care as soon as possible.

   a. Service providers notify the Division/assigned AdSS promptly when members test positive for pregnancy.

   b. In addition, the AdSS must have an ongoing process to monitor and evaluate the effectiveness of outreach activities for all members who are pregnant. If activities prove to be ineffective, the AdSS must implement different activities.

4. Participation in community and quality initiatives within the communities served by the AdSS.

5. Implementation of written protocols to inform members who are pregnant and maternity care providers of voluntary prenatal HIV testing and the availability of counseling, if the test is positive.

   a. Each AdSS must include information to encourage members who are pregnant to be tested and provide instructions on where testing is available at least annually in the member newsletter, new member welcome packet, maternity packet, provider instructions, and the member handbook.

   b. AdSS must report to the Division the number of members who are pregnant who have been identified as HIV positive within the timeframes indicated in Contract Exhibit C, Deliverables.

6. Designation of a maternity care provider for each member who is pregnant for the duration of her pregnancy and postpartum care. Such designations must allow for freedom of choice, while not compromising the continuity of care. Members who transition to a different AdSS or become newly enrolled with an AdSS during their third trimester must be allowed to complete maternity care with their current AHCCCS registered provider, regardless of contractual status, to ensure continuity of care.

7. Provision of information, regarding the opportunity to change AdSS to ensure continuity of prenatal care, to newly-assigned members who are pregnant and those currently under the care of a non-network provider.

8. New member assessment procedures for the provider that include identifying risk factors through the use of a comprehensive assessment tool covering psychosocial, nutritional, medical and educational factors (available from the American Congress of Obstetricians and Gynecologists [ACOG] or the Mutual Insurance Company of Arizona [MICA]).

9. Mandatory availability of maternity care coordination services for members who are pregnant, who are determined to be medically or socially at-risk/high-risk by the maternity care provider or the AdSS. This includes identified difficulties with navigating the health care system, evident by missed visits, transportation difficulties, or other perceived barriers.

10. Demonstration of an established process for assuring:

    a. Network physicians, practitioners, and licensed midwives adhere to the highest standards of care, including the use of a standardized medical risk assessment tool for initial and ongoing risk assessments, and appropriate consults/referrals for increased-risk or high-risk pregnancies using ACOG or MICA criteria.

    b. Maternity care providers educate members about healthy behaviors during pregnancy, including the importance of proper nutrition; dangers of lead exposure to mother and child; tobacco cessation; avoidance of alcohol and other harmful substances, including illegal drugs; screening for sexually transmitted infections; the physiology of pregnancy; the process of labor and delivery; breast-feeding; other infant care information; and postpartum follow-up.

    c. Members are referred for support services to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), as well as other community- based resources to support healthy pregnancy outcomes. If a member loses eligibility, the member must be notified where they may obtain low-cost or no-cost maternity services.

    d. Maternity care providers maintain a complete medical record, documenting all aspects of maternity care.

    e. High-risk members who are pregnant have been referred to and are receiving appropriate care from a qualified physician.

    f. Postpartum services are provided to members within 57 days of delivery.

11. Mandatory provision of initial prenatal care appointments within the established timeframes. The established timeframes are as follows:

    a. First trimester - within 14 days of a request for an appointment

    b. Second trimester - within seven days of a request for an appointment

c. Third trimester - within three days of a request for an appointment, or

d. High-risk pregnancy care must be initiated within three days of identification or immediately, if an emergency exists.

12. Primary verification of members who are pregnant, to ensure that the above-mentioned timeframes are met, and to effectively monitor members are seen in accordance with those timeframes.

13. Monitoring and evaluation of infants born with low/very low birth weight, and implementation of interventions to decrease the incidence of infants born with low/very low birth weight.

14. Monitoring and evaluation of cesarean section and elective induction rates prior to 39 weeks gestation, and implementation of interventions to decrease occurrence.

15. Identification of postpartum depression and referral of members to the appropriate health care providers.

    AdSS may refer to *Tool Kit for the Management of Adult Postpartum Depression (*AMPM Appendix F), which is intended to assist the provider in assessing the postpartum needs of women regarding depression and decisions regarding health care services provided by the PCP or subsequent referral for behavioral health services if clinically indicated.

16. Process for monitoring provider compliance for perinatal/postpartum depression screenings being conducted at least once during the pregnancy and then repeated at the postpartum visit, with appropriate counseling and referrals made, if a positive screening is obtained.

17. Return visits in accordance with ACOG standards. A process, with primary verification, must be in place to monitor these appointments and ensure timeliness. The AdSS must include the first and last prenatal care dates of service and the number of obstetrical visits that the member had with the provider on claim form regardless of the payment methodology. The AdSS must continue to pay obstetrical claims upon receipt of claim after delivery, and must not postpone payment to include the postpartum visit. Rather, the AdSS must require a separate “zero-dollar” claim for the postpartum visit.

18. Timely provision of medically necessary transportation services, as described in Division Medical Policy 310-BB, Transportation.

19. Postpartum activities must be monitored and evaluated, and interventions to improve the utilization rate implemented, where needs are identified.

20. Participation of the AdSS in reviews of the maternity care services program conducted by the Division or AHCCCS as requested, including provider visits and audits.

B. Requirements for the Maternity/Family Planning Services Annual Plan

Each Administrative Services Subcontractor (AdSS) must have a written Maternity/Family Planning Services Annual Plan that addresses minimum AdSS requirements as specified in the prior section (numbers 1 through 20), as well as the objectives of the AdSS's program that are focused on achieving Division and AHCCCS requirements. It must also incorporate monitoring and evaluation activities for these minimum requirements; see *Maternity/ Family Planning Services Annual Plan Checklist* (AHCCCS Medical Policy Manual [AMPM] Exhibit 400-2A) as adopted for use by the Division. The Maternity/Family Planning Services Annual Plan must be submitted to Division Health Care Services Unit through the Division Compliance Unit no later than the date specified in Contract Chart of Deliverable and is subject to approval (see AMPM Exhibit 400-1, *Maternal and Child Health Reporting Requirements*). The Maternity/Family Planning Services Annual Plan must contain, at a minimum, the following:

1. Maternity/Family Planning Services Care Plan – A written, narrative description of all planned activities to address the AdSS's minimum requirements as specified in the prior section (Requirements for Providing Maternity Care Services - Numbers 1 through 20) for maternity care and family planning services, including participation in community and/or quality initiatives within the communities served by the AdSS. The narrative description must also include AdSS activities to identify member needs, coordination of care, and follow-up activities to ensure appropriate and medically necessary treatment is received in a timely manner.

2. Maternity/Family Planning Services Work Plan Evaluation – An evaluation of the previous year's Work Plan to determine the effectiveness of strategies and interventions used toward meeting stated objectives.

3. Maternity/Family Planning Services Work Plan that includes:

    a. Specific measurable objectives

        These objectives must be based on Division and AHCCCS established minimum performance standards. In cases where Division and AHCCCS minimum performance standards have been met, other generally accepted benchmarks that continue the AdSS's improvement efforts must be used (e.g., National Committee on Quality Assurance, Healthy People 2020 standards). The AdSS may also develop additional specific measurable goals and objectives aimed at enhancing the maternity program when Division and AHCCCS Minimum Performance Standards have been met.

    b. Strategies and specific measurable interventions to accomplish objectives (e.g., member outreach, provider education and provider compliance with mandatory components of the Maternity/Family Planning Services program)

    c. Targeted implementation and completion dates of work plan activities

d. Assigned local staff position(s) responsible and accountable for meeting each established goal and objective

e. Identification and implementation of new interventions, continuation of or modification to existing interventions, based on analysis of the previous year's Work Plan Evaluation.

4. Relevant policies and procedures, referenced in the Maternity/Family Planning Services Annual Plan, submitted as separate attachments.

C. Maternity Care Provider Requirements

1. Physicians and practitioners must follow the American Congress of Obstetricians and Gynecologists standards of care, including the use of a standardized medical risk assessment tool and ongoing health risk assessment.

2. Licensed midwives, if included in the AdSS's provider network, adhere to the requirements contained within Division and AHCCCS policy, procedures, and contracts.

3. All maternity care providers will ensure that:

a. High-risk members have been referred to a qualified provider and are receiving appropriate care.

b. All pregnant members are screened through the Controlled Substances Prescription Monitoring Program (CSPMP) once a trimester, and for those members receiving opioids, appropriate intervention and counseling must be provided, including referral of members for behavioral health services as indicated for Substance Use Disorder (SUD) assessment and treatment,

c. Members are educated about healthy behaviors during pregnancy, including the importance of proper nutrition; dangers of lead exposure to mother and child; tobacco cessation; avoidance of alcohol and other harmful substances, including illegal drugs; screening for sexually transmitted infections; the physiology of pregnancy; the process of labor and delivery; breastfeeding; other infant care information; and postpartum follow-up.

d. Perinatal and Postpartum depression screenings are conducted at least once during the pregnancy and then repeated at the postpartum visit with appropriate counseling and referrals made, if a positive screening is obtained. Postpartum depression screening is considered part of the global service and is not a separately reimbursable service.

Providers should refer to AHCCCS Medical Policy Manual, Appendix F, *Tool Kit for the Management of Adult Postpartum Depression*, which is intended to assist the provider in assessing the postpartum needs of women regarding depression and decisions regarding health care

services provided by the PCP or subsequent referral for Behavioral Health Services if clinically indicated.

e. Member medical records are appropriately maintained and document all aspects of the maternity care provided.

f. Members must be notified that, in the event they lose eligibility for services, they may contact Arizona Department of Health Services (ADHS) Hotline for referrals to low-cost or no-cost services.

g. The first and last prenatal care dates of service, as well as the number of obstetrical visits that the member had with the provider, are recorded on all claim forms submitted to the AdSS regardless of the payment methodology used.

h. Postpartum services must be provided to members within 57 days of delivery using a separate “zero-dollar” claim for the postpartum visit.

D. Additional Covered Related Services

Additional Covered related services with special policy and procedural guidelines include, but are not limited to:

1. Circumcision is a covered service under EPSDT for males who are eligible for ALTCS or Targeted Support Coordination, when it is determined to be medically necessary. The procedure requires Prior Authorization (PA) by the AdSS Medical Director or designee for enrolled members.

2. Extended Stays for Newborns Related to Status of Mother’s Stay

a. The Division covers no less than 48 hours of inpatient hospital care for a vaginal delivery without complications and no less than 96 hours of inpatient hospital care for a cesarean delivery without complications.

b. The mother of the newborn may be discharged prior to the minimum 48/96 hour stay, if agreed upon by the mother in consultation with the physician or practitioner. A normal newborn may be granted an extended stay in the hospital of birth when the mother’s continued stay in the hospital is beyond the minimum 48 or 96 hour stay, whichever is applicable. In addition, if the mother's stay is to extend beyond 48/96 hours, an extended stay for the newborn should be granted if the mother's condition allows for mother-infant interaction and the child is not a ward of the state or is not to be adopted.

3. Home Uterine Monitoring Technology

   a. Medically necessary home uterine monitoring technology is covered for members with premature labor contractions before 35 weeks gestation, as an alternative to hospitalization.

   b. If the member has one or more of the following conditions, home uterine monitoring may be considered:

      i. Multiple gestation, particularly triplets or quadruplets

      ii. Previous obstetrical history of one or more births before 35 weeks gestation

      iii. Hospitalization for premature labor before 35 weeks gestation with a documented change in the cervix, controlled by tocolysis and ready to be discharged for bed rest at home.

   c. These guidelines refer to home uterine activity monitoring technology and do not refer to daily provider contact by telephone or home visit.

4. Labor and Delivery Services Provided in Freestanding Birthing Centers

   a. For members who meet medical criteria specified in this policy, the Division covers freestanding birthing centers when labor and delivery services are provided by licensed physicians or certified nurse practitioners in midwifery (a.k.a. certified nurse midwives).

   b. Freestanding birthing centers are defined as out-of-hospital, outpatient obstetrical facilities, licensed by the Arizona Department of Health Services and certified by the Commission for the Accreditation of Free Standing Birth Centers. They are equipped to manage uncomplicated, low-risk labor and delivery. These facilities must be affiliated with, and in close proximity to, an acute care hospital for the management of complications, should they arise.

   c. Labor and delivery services rendered through freestanding birthing centers must be provided by a physician, (i.e., the member's primary care provider or an obstetrician with hospital admitting privileges) or by a registered nurse who is accredited/certified by the American College of Nurse Midwives and has hospital admitting privileges for labor and delivery services.

   d. Only members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated may be scheduled to deliver at a freestanding birthing center. Risk status must be determined by the attending physician or certified nurse midwife, using the standardized assessment tools for high-risk pregnancies (American Congress of Obstetricians and Gynecologists, Mutual Insurance Company of Arizona, of National Association of

Childbearing Centers). In any area of the risk assessment where standards conflict, the most stringent will apply. The age of the member must also be a consideration in the risk status evaluation; members younger than 18 years of age are generally considered high risk. Refer to A.A.C. R9-16-111 through 113 for a more detailed explanation of what are not considered low-risk deliveries, nor appropriate for planned home-births or births in freestanding birthing centers.

5. Labor and Delivery Services Provided in a Home Setting

   a. The Division covers labor and delivery services provided in the home by the member's maternity provider (physicians, certified nurse midwives, and licensed midwives).

   b. Refer to A.A.C. R9-16-111 through 113 for a more detailed explanation of what are not considered low-risk deliveries nor appropriate for planned home-births or births in freestanding birthing centers.

   c. Risk status must initially be determined at the time of the first visit, and each trimester thereafter, by the member's attending physician, practitioner, or licensed midwife, using the current standardized assessment criteria and protocols for high- risk pregnancies from the American Congress of Obstetrics and Gynecology or Mutual Insurance Company of Arizona.

   d. A risk assessment must be conducted when a new presenting complication or concern arises to ensure appropriate care and referral to a qualified provider, if necessary.

   e. Physicians and practitioners who render home labor and delivery services must have admitting privileges at an acute care hospital in close proximity to the site where the services are provided in the event of complications during labor and/or delivery.

   f. For each anticipated home labor and delivery, licensed midwives who render home labor and delivery services must have an established plan of action, including methods of obtaining services at an acute care hospital in close proximity to the site where services are provided. In addition, referral information to an AHCCCS registered physician who can be contacted immediately, if management of complications is necessary, must be included in the plan.

   g. Upon delivery of the newborn, the physician, certified nurse midwife, or licensed midwife is responsible for conducting newborn examination procedures, including a mandatory Bloodspot Newborn Screening Panel and referral of the infant to an appropriate health care provider for a mandatory hearing screening, as well as a second mandatory Bloodspot Newborn Screening Panel and second newborn

hearing screening (if infant refers on first testing). Refer the infant and/or member to an appropriate health care provider for follow-up care of any assessed problematic conditions (refer to A.A.C. R9-16-111 through 113).

6. Licensed Midwife Services

   a. The Division covers maternity care and coordination provided by licensed midwives for members, if licensed midwives are included in the AdSS's provider network. In addition, members who choose to receive maternity services from this provider type must meet eligibility and medical criteria specified in this policy.

   b. The age of the member must be included as a consideration in the risk status evaluation. Refer to A.A.C. R9-16-111 through 113 for a more detailed explanation of what are not considered low-risk deliveries, nor appropriate for planned home-births, or births in freestanding birthing centers.

   c. Risk status must initially be determined at the time of the first visit, and each trimester thereafter, using the current standardized assessment criteria and protocols for high-risk pregnancies from the American Congress of Obstetrics and Gynecology or Mutual Insurance Company of Arizona.

   d. A risk assessment from the American Congress of Obstetrics and Gynecology or Mutual Insurance Company of Arizona must be conducted when a new presenting complication or concern arises to ensure proper care and referral to a qualified physician if necessary.

   e. Before providing licensed midwife services, documentation certifying the risk status of the member's pregnancy must be submitted to the member's assigned AdSS. In addition, a consent form signed and dated by the member must be submitted, indicating that the member has been informed and understands the scope of services that will be provided by the licensed midwife, including risks to a home delivery. Members initially determined to have a high-risk pregnancy, or members whose physical condition changes to high-risk during the course of pregnancy, must immediately be referred to an AHCCCS registered physician within the provider network of the member's assigned AdSS for maternity care services.

   f. Labor and delivery services provided by a licensed midwife cannot be provided in a hospital or other licensed health care institution. Licensed midwives must have a plan of action, including the name and address of an AHCCCS registered physician and an acute care hospital in close proximity to the planned location of labor and delivery for referral, if complications should arise. This plan of action must be submitted to the AdSS Medical Director or designee for members enrolled with an AdSS.

g. Upon delivery of the newborn, the licensed midwife is responsible for conducting newborn examination procedures, including a mandatory Bloodspot Newborn Screening Panel and referral of the infant to an appropriate health care provider for a mandatory hearing screening, as well as a second mandatory Bloodspot Newborn Screening Panel and a second newborn hearing screening (if infant refers on first testing). Refer the infant and/or member to an appropriate health care provider for follow-up care of any assessed problematic conditions (refer to A.A.C. R9-16-111 through 113).

h. In addition, the licensed midwife must notify the mother's AdSS, of the birth no later than three days after the birth, in order to enroll the newborn with AHCCCS.

7. Supplemental Stillbirth Payment

Implemented to cover the cost of delivery services. The supplemental payment applies to all births to women enrolled with the AdSS. The Division also pays this supplement to the AdSS when the infant is stillborn. Stillbirth refers to those infants, deemed a fetal demise prior to delivery with a gestational age greater than 24 and 0/7 weeks. In order for AdSS to be eligible to receive this payment, criteria must be met. The stillborn infant must have:

a. Attained a weight of at least 600 grams, or

b. Attained a gestational age of at least 24 and 0/7 weeks, as verified by Provider's obstetrical prenatal records (History & Physical) including an Estimated Date of Confinement (EDC). An ultrasound report may also be used to verify EDC, when completed prior to 20 weeks gestation. A Ballard Assessment, done at delivery by nursing and/or physician staff to determine physical maturity of the infant, confirming a gestational age of at least 24 and 0/7 weeks may also be used.

For stillbirths meeting one of the above medical criteria, AdSS must submit to Division's Health Care Services Unit through the Division's Compliance Unit medical documentation to confirm infant's weight and/or gestational age, as well as the date/time of delivery and zero APGARs, using the *AHCCCS Request for Stillbirth Supplement* form (AMPM Attachment 410-B) as adopted for use by the Division. For American Indian Health Program (AIHP), the request must be submitted to the Division's Health Care Services through the Division's Compliance Unit using secure email to the Division's Health Care Services at dddqocaudits@azdes.gov and copying dddaltcscompliance@azdes.gov or by mailing it to the address indicated below.

AHCCCSEPSDT Maternal Child Health Manager in the Division's Health Care Services Clinical Quality Management Unit/MCH Manager

Mail Drop 2C91
3443 N. Central Ave.
Phoenix, AZ 85012P

No supplemental payment is provided for labor and delivery services rendered during the prior period coverage timeframe, or if the member was not assigned to the AdSS at the time labor and delivery services were rendered.

AdSS requests for the payment must be made within four months of the delivery date, unless an exemption is granted by the Division's Chief Medical Officer or Medical Director through the Health Care Services Unit. Exemptions will be considered on a case-by-case basis.

8. Pregnancy Termination (including Mifepristone [Mifeprex or RU-486])

a. Pregnancy termination is covered if one of the following criteria is present:

i. The pregnant member suffers from a physical disorder, physical injury, or physical illness including a life-endangering physical condition caused by, or arising from, the pregnancy itself that would, as certified by a physician, place the member in danger of death unless the pregnancy is terminated.

ii. The pregnancy is a result of incest.

iii. The pregnancy is a result of rape.

iv. The pregnancy termination is medically necessary according to the medical judgment of a licensed physician, who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or behavioral health problem for the pregnant member by:

- Creating a serious physical or behavioral health problem for the pregnant member
- Seriously impairing a bodily function of the pregnant member
- Causing dysfunction of a bodily organ or part of the pregnant member
- Exacerbating a health problem of the pregnant member, or

- Preventing the pregnant member from obtaining treatment for a health problem.

b. Acknowledgement

The attending physician must acknowledge that a pregnancy termination was necessary based on the above criteria by submitting the *AHCCCS Certificate of Necessity for Pregnancy Termination* (AMPM Attachment 410-C) and supporting clinical documentation to the Division.

The certificate must be submitted to the Division's Chief Medical Officer or designee for enrolled pregnant members eligible for ALTCS. The Certificate must certify that, in the physician's professional judgment, one or more of the above criteria have been met.

c. Additional Required Documentation

i. A written informed consent must be obtained by the provider and kept in the member's chart for all pregnancy terminations. If the pregnant member is younger than 18 years of age, or is 18 years of age or older and considered an incapacitated adult (as defined in A.R.S. 14-5101), a dated signature of the pregnant member's parent or legal guardian indicating approval of the pregnancy termination procedure is required.

ii. When the pregnancy is the result of rape or incest, documentation must be obtained that the incident was reported to the proper authorities, including the name of the agency to which it was reported, the report number (if available), and the date the report was filed. This documentation requirement must be waived if the treating physician certifies that, in his or her professional opinion, the member was unable, for physical or psychological reasons, to comply with the requirement.

d. Additional Considerations Related to Use of Mifepristone

i. Mifepristone (also known as Mifeprex or RU-486) is not a post-coital emergency oral contraceptive. The administration of Mifepristone for the purposes of inducing intrauterine pregnancy termination is covered when a minimum of one required criterion is met for pregnancy termination, as well as the following conditions specific to Mifepristone:

- Mifepristone can be administered through 49 days of pregnancy.

- If the duration of pregnancy is unknown or if ectopic pregnancy is suspected, ultrasonography should be used for confirmation.

- Any Intrauterine Device ("IUD") should be removed before treatment with Mifepristone begins.
- 400 mg. of Misoprostol must be given two days after taking Mifepristone unless a complete pregnancy termination has already been confirmed.
- Pregnancy termination by surgery is recommended in cases when Mifepristone and Misoprostol fail to induce termination of the pregnancy.

ii. When Mifepristone is administered, documentation of the following is also required:

- Duration of pregnancy in days
- The date IUD was removed if the member had one
- The date Mifepristone was given
- The date Misoprostol was given
- That pregnancy termination occurred.

e. Pregnancy Termination Monthly Report

Note: The AdSS must submit a standardized *AHCCCS Monthly Pregnancy Termination Report* (AMPM Attachment 410-E), as adopted for use by the Division, to Division's Health Care Services Unit, which documents the number of pregnancy terminations performed during the month (including pregnancy terminations resulting from the use of Mifepristone). Mifepristone). If no pregnancy terminations were performed during the month, the monthly report must still be submitted to attest to that information.

When pregnancy terminations have been authorized by the AdSS, the following information must be provided with the monthly report:

i. A copy of the completed *AHCCCS Certificate of Necessity for Pregnancy Termination* (AMPM Attachment 410-C), which has been signed by the AdSS's Medical Director

ii. A copy of the completed *AHCCCS Verification of Diagnosis by Contractor for a Pregnancy Termination Request* (AMPM Attachment 410-D) confirming requirements for pregnancy termination have been met

iii. A copy of the official incident report, in the case of rape or

incest unless the physician certifies in her or her professional opinion the member was unable for physical or psychological reasons to comply with the requirement to report the rape and/or incest to authorities

iv. A copy of documentation confirming pregnancy termination occurred

v. A copy of the clinical information supporting the justification/necessity for pregnancy termination.

f. Prior Authorization (PA)

Except in cases of medical emergencies, the provider must obtain a PA for all covered pregnancy terminations from the Division's Chief Medical Officer or designee. All PA requests must include:

i. *TAHCCCS Certificate of Necessity for Pregnancy Termination* (AMPM Attachment 410-C)

ii. *TAHCCCS Verification of Diagnosis by Contractor for Pregnancy Termination Request* (AMPM Attachment 410-D)

iii. Any lab, radiology, consultation or other testing results that support the justification/necessity for pregnancy termination.

The AdSS, or the Division for members eligible for AIHP, must contact the provider to confirm the qualifying diagnosis/condition within 24 hours of receiving the PA request for a pregnancy termination and must include a signature attesting that an authorization decision was made after contact with the provider to determine that the member had the qualifying diagnosis/condition and the supporting documentation had been received. The Division's Chief Medical Officer or designee will review the PA request, the *AHCCCS Certificate of Necessity for Pregnancy Termination,* and the *AHCCCS Verification of Diagnosis by Contractor for Pregnancy Termination Request forms* and expeditiously authorize the procedure, if the documentation meets the criteria for justification of pregnancy termination.

In cases of medical emergencies, the provider must submit all documentation of medical necessity to the Division for members eligible for AIHP or the AdSS PA Unit within two working days of the date on which the pregnancy termination procedure was performed.

411 WOMEN'S PREVENTATIVE CARE SERVICES

EFFECTIVE DATE: May 27, 2016

Annual well-woman preventative care visit(s) are a covered benefit for women to obtain the recommended preventive services, including preconception counseling.

A well-woman preventative care visit is covered on an annual basis when clinically indicated.

A. Well-Woman Preventative Care Services include:

1. Human Papillomavirus (HPV) – An immunization for a sexually transmitted infection available for both males and females beginning at a recommended age of 11 years up to 26 years of age.

2. Family Planning Counseling - The provision of accurate information and discussion with a health care provider to allow members to make informed decisions about the specific family planning methods available that align with the member's lifestyle.

3. Mammogram - An x-ray of the breast used to look for early signs of breast cancer. Coverage does not include genetic testing.

4. Clinical Breast Exam - A physical examination of the breasts by a health care provider used as a primary diagnostic procedure for early detection of breast cancer.

5. Preconception Counseling – Counseling aimed at identifying/reducing behavioral and social risks, through preventive and management interventions, in women of reproductive age who are capable of becoming pregnant, regardless of whether she is planning to conceive.

    a. This counseling focuses on the early detection and management of risk factors before pregnancy and includes efforts to influence behaviors that can affect a fetus prior to conception.

    b. The purpose of preconception counseling is to ensure that a woman is healthy prior to pregnancy.

    c. Does not include genetic testing.

6. Well Exam - A physical examination in the absence of any known disease, symptom, or specific medical complaint by the member precipitating the examination.

B. Requirements for Well-Woman Preventative Care Services:

1. The Division's contracted health plans are responsible for covering Well-Woman Preventative Care Services for Division members enrolled in one of the plans.

2. The Division covers Well-Woman Preventative Care Services for Division members enrolled in the American Indian Health Plan (AIHP).

420 FAMILY PLANNING

REVISION DATE: 8/22/2018, 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994

Family planning services, when provided by physicians or practitioners, are covered for male and female members who voluntarily choose to delay or prevent pregnancy. Family planning services include covered medical, surgical, pharmacological, and laboratory benefits specified in this policy. Covered services also include the provision of accurate information and counseling to allow members to make informed decisions about specific family planning methods available, as discussed below in section A.1. Members may choose to obtain family planning services and supplies from any appropriate provider with the AdSS's network.

Members whose eligibility continues, may remain with their assigned maternity provider or exercise their option to select another provider for family planning services.

A. Covered family planning services for members include the following medical, surgical, pharmacological, and laboratory services as well as contraceptive devices (including Intrauterine Devices [IUDs] and subdermal implantable contraceptives):

1. Contraceptive counseling, medication, and/or supplies, including, but not limited to: oral and injectable contraceptives, Long-Acting Reversible Contraceptives (LARC), diaphragms, condoms, foams, and suppositories

2. Associated medical and laboratory examinations and radiological procedures, including ultrasound studies related to family planning

3. Treatment of complications resulting from contraceptive use, including emergency treatment

4. Natural family planning education or referral to qualified health professionals

5. Post-coital emergency oral contraception within 72 hours after unprotected sexual intercourse (Mifepristone, also known as Mifeprex or RU-486, is not post-coital emergency oral contraception)

6. Sterilization

   Clarification Related to Hysteroscopic Tubal Sterilization

   a. Hysteroscopic tubal sterilization is not immediately effective upon insertion of the sterilization device. It is expected that the procedure will be an effective sterilization procedure three months following insertion. Therefore, during the first three months the member must continue using another form of birth control to prevent pregnancy.

   b. At the end of the three months, it is expected that a Hysterosolpingogram will be performed confirming that the member is sterile. After the confirmatory test the member is considered sterile.

B. Coverage for the following family planning services are as follows:

1. Pregnancy screening is a covered service.

2. Pharmaceuticals are covered when associated with medical conditions related to family planning or other medical conditions.

3. Screening and treatment for Sexually Transmitted Infections (STI) are covered services for both male and female members.

4. Sterilization services are covered for both male and female members when the requirements specified in this policy for sterilization services are met (including hysteroscopic tubal sterilizations).

5. Pregnancy termination is covered only as specified in Division Medical Policy 410 (including Mifeprsitone [Mifeprex or RU-486]).

C. Limitations

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

1. Infertility services including diagnostic testing, treatment services and reversal of surgically induced infertility

2. Pregnancy termination counseling

3. Pregnancy terminations except as specified in Division Medical Policy 410 [including Mifeprsitone (Mifeprex or RU-486)]

4. Hysterectomies for the purpose of sterilizations

AdSS Requirements for Providing Family Planning Services

The AdSS must ensure that service delivery, monitoring, and reporting requirements are met. The AdSS must:

A. Plan and implement an outreach program to notify members of reproductive age of the specific covered family planning services available and how to request them. Notification must be in accordance with A.R.S. §36.2904(L). The information provided to members must include, but is not limited to:

1. A complete description of covered family planning services available

2. Information advising how to request/obtain these services

3. Information that assistance with scheduling is available

4. A statement that there is no charge for these services.

B. Have policies and procedures in place to ensure that maternity care providers are educated regarding covered and non-covered services, including family planning services available to members.

C. Have family planning services that are:

1. Provided in a manner free from coercion or behavioral/mental pressure

2. Available and easily accessible to members

3. Provided in a manner which assures continuity and confidentiality

4. Provided by, or under the direction of, a qualified physician or practitioner

5. Documented in the medical record. In addition, documentation must be recorded that each member of reproductive age was notified verbally or in writing of the availability of family planning services.

D. Incorporate medical audits for family planning services with quality management activities to determine conformity with acceptable medical standards.

E. Establish quality/utilization management indicators to effectively measure/monitor the utilization of family planning services.

F. Have written practice guidelines that detail specific procedures for the provision of LARC. (For more information on LARC, see "Arizona DRG Payment Policies" on the AHCCCS website at www.azahcccs.gov). These guidelines must be written in accordance with acceptable medical standards.

G. Implement a process to ensure that, prior to insertion of intrauterine and subdermal implantable contraceptives, the maternity care provider has provided proper counseling to the eligible member to minimize the likelihood of a request for early removal. Counseling information is to include a statement to the member indicating if the implant is removed within two years of insertion, the member may not be an appropriate candidate for reinsertion for at least one year after removal.

Protocol for Member Notification of Family Planning Services and AdSS Reporting Requirements

The AdSS is responsible for providing family planning services and notifying members regarding the availability of covered services. The AdSS must establish processes to ensure the sterilization reports specified in this policy comply with the procedural guidelines for encounter submissions. The Division will notify all members eligible under the category of pregnant woman, who become ineligible for DD-long term care.

AdSS will provide information about covered family planning services to include:

A. Member notification of these covered services must meet the following minimum requirements:

1. In accordance with A.R.S. §36-2904(L), AdSSs must notify members of reproductive age either directly or through the parent or legal guardian, whichever is most appropriate, of the specific covered family planning services available to them, and a plan to deliver those services to members who request them. Notification must include provisions for written

notification, other than the member handbook, and verbal notification during a member's visit with the member's primary care physician or primary care practitioner.

2. Notification of family planning services must include provision for written notification in addition to the Member Handbook and the member newsletter. Communications and correspondence dealing specifically with notification of family planning services are acceptable methods of providing this information. The communications and correspondence must be approved by the Division and conform to confidentiality requirements

3. Notification is to be given at least once a year and must be completed by November 1st. For members who enroll with the AdSS after November 1st, notification must be sent at the time of enrollment.

4. Notification must include all of the covered family planning services as well as instructions to members regarding how to access these services.

5. As with other member notifications, notification must be written at an easily understood reading level.

6. Notification must be presented in accordance with cultural competency requirements.

7. The AdSS must monitor compliance to ensure the Maternity Care Providers verbally notify members of the availability of family planning services during office visits.

8. The AdSS must report all members under 21 years of age, undergoing a procedure that renders the member sterilized, using the *AHCCCS Sterilization Reporting Form for Members under 21 Years of Age* (AMPM Attachment 420-B) as adopted for use by the Division. Documentation supporting the medical necessity for the procedure shall be submitted with the reporting form.

Sterilization

The following requirements regarding member consent for sterilization services apply to AdSSs (For more information refer to 42 CFR 50.203 and 204).

A. The following criteria must be met for the sterilization of a member to occur:

1. The member is at least 21 years of age at the time the consent is signed (AMPM Attachment 420-B).

2. The member has not been declared mentally incompetent.

3. Voluntary consent was obtained without coercion.

4. Thirty days, but not more than 180 days, have passed between the date of informed consent and the date of sterilization, except in the case of a premature delivery of emergency abdominal surgery. Members may consent

to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since they gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

B. Any member requesting sterilization must sign an appropriate consent form AHCCCS Consent to Sterilization form (AMPM Attachment 420-A) with a witness present when the consent is obtained. Suitable arrangements must be made to ensure that the information in the consent form is effectively communicat3ed to members with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds, as well as members with visual and/or auditory limitations. Prior to signing the consent form, a member must first have a copy of the consent form and offered factual information that includes all of the following:

1. Consent form requirements (See 42 CFR. 50.204)
2. Answers to questions asked regarding the specific procedure to be performed
3. Notification that withdrawal of consent can occur at any time prior to surgery without affecting future care and/or loss of federally funded program benefits
4. Advice that the sterilization procedure is considered to be irreversible
5. A thorough explanation of the specific sterilization procedure to be performed
6. A description of available alternative methods
7. A full description of the discomforts and risk that may accompany or follow the performing of the procedure, including an explanation of the types and possible effects of any anesthetic to be used
8. A full description of the advantages or disadvantages that may be expected as a result of the sterilization
9. Notification that sterilization cannot be performed for at least 30 days post consent.

C. Sterilization consents may not be obtained when a member:

1. Is in labor or childbirth
2. Is seeking to obtain, or is obtaining, a pregnancy termination, or
3. Is under the influence of alcohol or other substances that affect that member's state of awareness.

430 EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT SERVICES

REVISION DATE: 3/25/2016, 7/3/2015, 4/15/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994
REFERENCES: Division Medical Policy Manual, 310-P, Medical Supplies, http://www.azahcccs.gov/Regulations/lawsregulations.aspx

Maternal and Child Health

There are several programs that support maternal and child health. These include Early and Periodic Screening, Diagnosis and Treatment (EPSDT); family planning; pregnant women's program; and mental health. These programs are described below:

A. EPSDT is the component of the Medicaid Program established in 1969 as the federally mandated screening and treatment program for children, birth to age 21.

The goal of EPSDT is to provide health care through primary prevention, early intervention, diagnosis, and medically necessary treatment of physical and behavioral health problems identified by well child checks and screens.

An EPSDT must include:

1. A comprehensive health and developmental history (including both physical and behavioral health assessment);

2. As of January 1, 2006, the Prenatal Evaluation of Development Status (PEDS) developmental screening tool should be utilized for developmental screening by the primary care provider for EPSDT-age members who were admitted to the neonatal intensive care unit. The PEDS screening should also be conducted at each EPSDT well child visit;

3. A comprehensive unclothed physical examination;

4. Appropriate immunizations according to age and health history;

5. Laboratory tests (including blood lead levels);

6. Health education;

7. Appropriate dental screening;

8. Appropriate vision screening and hearing testing; and,

9. Diagnostic services whenever a screening examination indicates the need to conduct a more in depth evaluation of the child's health status and to provide diagnostic studies.

As the Medicaid authority in Arizona, Arizona Health Care Cost Containment System (AHCCCS) administers the Early and Periodic Screening Diagnosis and Treatment program. Children who are eligible for Medicaid are eligible for EPSDT services. Children who are eligible for Arizona Long Term Care System (ALTCS) services are also Medicaid eligible. Additionally, these children are eligible for EPSDT services.

AHCCCS, contracts with health plans to provide all EPSDT services to all AHCCCS eligible children in Arizona.

The Division also contracts with the health plans to provide EPSDT services to children who are ALTCS eligible. The Division provides those services identified as habilitative to children who are ALTCS eligible. The health plans are under contract to provide rehabilitative services to children who are ALTCS eligible.

Medicaid funds are available to pay for medically necessary services identified for a child with a disability in his/her Individualized Educational Plan, Individual Family Service Plan, Individual Support Plan or Person Centered Plan.

All services authorized in the federal Medicaid law must be provided to children who are eligible for EPSDT. These services include:

1. Screening;
2. Evaluation;
3. Clinic services;
4. Rehabilitative services;
5. Physical therapist services;
6. Occupational therapist services;
7. Speech pathology and audiology services;
8. Psychological treatment;
9. Social services;
10. Inpatient psychiatric facility services; and,
11. Outpatient behavioral health services.

An authorization for services can only be denied for lack of a finding of medical necessity. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services. It cannot be denied for any other reason for children who are eligible for the AHCCCS program and Division services.

EPSDT means those procedures or professional services which are required to maintain, correct or ameliorate a physical, emotional or developmental problem which is discovered through screening, examination or evaluation or which is found to have worsened since a previous screening.

For more detailed information on EPSDT, refer to the AHCCCS Medical Policy Manual, section 430. http://www.azahcccs.gov/Regulations/lawsregulations.aspx

B. Behavioral Health Programs – members who are eligible for ALTCS services needing behavioral health services may be referred by their Division Support Coordinator, the Division Behavioral Health Coordinator, and the physician or by themselves to a Regional Behavioral Health Authority (RBHA) for evaluation and service planning. Covered services must comply with the AHCCCS behavioral health policies and procedures. Inpatient and outpatient services are covered as well as appropriate prescription drugs.

C. Incontinence Briefs

1. The Division's acute care contracted health plans shall provide incontinence briefs, including pull-ups and incontinence pads, for members who are between 3 and 21 years of age and who are eligible for the Arizona Long Term Care System (ALTCS) services. Briefs may be provided in order to prevent skin breakdown and to enable participation in social, community, therapeutic and education activities. These supplies will be provided under the following circumstances:

   a. The member is incontinent due to a documented disability that caused incontinence of bowel and/or bladder.

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

   c. Incontinence briefs do not exceed 240 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 240 briefs per month for a member diagnosed with chronic diarrhea or spastic bladder.

   d. The member obtains incontinence briefs from providers in the Contractor's network.

   e. Apply appropriate prior authorization requirements. Prior authorization for a renewal of an existing prescription may be provided by the physician through telephone contact with the member rather than an in-person physician visit.

      Prior authorization is permitted to ascertain that:

      i. The member is over age 3 and under age 21;

ii. The member has a disability that causes incontinence of bladder and/or bowel;

iii. A physician has prescribed incontinence briefs as medically necessary. A physician prescription supporting medical necessity may be required for specialty briefs or for briefs different from the standard brief supplied by the contractor; and,

iv. The prescription is for 240 briefs of fewer per month, unless evidence of medical necessity for over 240 briefs is provided.

2. The Division shall provide incontinence briefs for members who are between 3 and 21 years of age who are:

   a. Group home residents that do not qualify for Medicaid (ALTCS or targeted).

   b. Group home residents that qualify for Medicaid (ALTCS) and have been denied incontinence briefs by the assigned health plan and other medical insurance coverage (e.g., Medicare), if applicable.

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

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

5. Incontinence briefs will not be covered by Children's Rehabilitative Services (CRS).

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

7. 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.

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

9. For information regarding incontinence briefs for members over the age of 21 see the Division Medical Policy Manual, 310-P, Medical Supplies, Durable Medical Equipment, and Prosthetic Devices (Acute Care Services.)

431 ORAL HEALTH CARE (EPSDT-AGE MEMBERS)

EFFECTIVE DATE: November 22, 2017

REFERENCES: 9 A.A.C. 22, Article 2; A.R.S. § 14-5101; AMPM Exhibits 400-1, 400-2C, 430-1 and 431-1

This policy applies to members under 21 years of age eligible for ALTCS (Early Periodic Screening, Diagnosis, and Treatment [EPSDT]). As part of the physical examination, the physician, physician's assistant, or nurse practitioner must perform an oral health screening. A screening is intended to identify gross dental or oral lesions, but it is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan. Depending on the results of the oral health screening, referral to a dentist must be made.

Appointment Standards

Emergent: Within 24 hours of request
Urgent: Within three days of request
Routine: Within 45 days of request

An oral health screening must be part of an EPSDT screening conducted by a Primary Care Provider (PCP). However, it does not substitute for examination through direct referral to a dentist. PCPs must refer members for appropriate services based on needs identified through the screening process and for routine dental care based on the AHCCCS EPSDT Periodicity Schedule. Evidence of this referral must be documented on the EPSDT Tracking Form and in the member's medical record.

PCPs who have completed the AHCCCS required training may be reimbursed for fluoride varnish applications completed at the EPSDT visits for members who are at least six months of age with at least one tooth eruption. Additional applications occurring every six months during an EPSDT visit, up until member's second birthday, may be reimbursed according to AHCCCS-approved fee schedules. Application of fluoride varnish by the PCP, does not take the place of a dental (oral health) visit.

AHCCCS-recommended training for fluoride varnish application is located on the Smiles for Life oral health website. Refer to Training Module 6, titled Caries Risk Assessment, Fluoride Varnish, and Counseling. Upon completion of the required training, providers must submit a copy of their certificate to each of the contracted health plans in which they participate, as this is required prior to issuing payment for PCP-applied fluoride varnish. This certificate may be used in the credentialing process to verify completion of training necessary for reimbursement.

Additional training resources may be found on the Arizona Department of Health Services website.

Dental Home

The American Academy of Pediatric Dentistry (AAPD) defines the dental home as "the ongoing relationship between the dentist and the member, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way" that must include:

A. Comprehensive oral health care including acute care and preventive services in accordance with AHCCCS Dental Periodicity Schedule

B. Comprehensive assessment for oral diseases and conditions

C. Individualized preventive dental health program based upon a caries-risk assessment and a periodontal disease risk assessment

D. Anticipatory guidance about growth and development issues (e.g., teething, digit, pacifier habits)

E. Plan for acute dental trauma

F. Information about proper care of the child's teeth and gingivae

This includes the prevention, diagnosis, and treatment of disease of the supporting and surrounding tissues and the maintenance of health, function, and esthetics of those structures and tissues.

G. Dietary counseling

H. Referrals to dental specialists when care cannot directly be provided within the dental home

Members must be assigned to a dental home by one year of age and seen by a dentist for routine preventative care according to the AHCCCS Dental Periodicity Schedule (AHCCCS Medical Policy Manual [AMPM] Exhibit 431-1). Members must be referred for additional oral health care concerns requiring additional evaluation and/or treatment.

The AHCCCS Dental Periodicity Schedule (AMPM Exhibit 431-1) identifies when routine referrals begin, however, PCPs may refer EPSDT members for a dental assessment at an earlier age, if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/or treatment by a dental professional. In addition to PCP referrals, EPSDT members are allowed self-referral to a dentist who is included in the Administrative Services Subcontractor's (AdSS's) provider network.

Covered Services

Members receiving EPSDT and Oral Health services through the Regional Behavioral Health Authority (RBHA) are only covered for members 18 to 21 years of age. All members age out of Oral Health & EPSDT services at age 21.

EPSDT covers the following dental services:

A. Emergency dental services including:

1. Treatment for pain, infection, swelling and/or injury

2. Extraction of symptomatic (including pain), infected, and non-restorable primary and permanent teeth, and retained primary teeth (extractions are limited to teeth which are symptomatic)

3. General anesthesia, conscious sedation, or anxiolysis (minimal sedation; members respond normally to verbal commands), when local anesthesia is contraindicated or when management of the member requires it. (See Division Medical Manual, Policy 430, regarding conscious sedation.)

B. Preventive dental services provided as specified in the AHCCCS Dental Periodicity Schedule (Exhibit 431-1), including but not limited to:

1. Diagnostic services including comprehensive and periodic examinations

   All AdSSs must allow two oral examinations and two oral prophylaxis and fluoride treatments per member per year (one every six months) for members 12 months to 21 years of age

2. Radiology services screening for diagnosis of dental abnormalities and/or pathology, including panoramic or full-mouth x-rays, supplemental bitewing x-rays, and occlusal or periapical films, as medically necessary and following the recommendations by the American Academy of Pediatric Dentistry.

   EPSDT covers panorex films as recommended by the American Academy of Pediatric Dentistry, up to three times maximum per provider for children between the ages of three to 20. Further panorex films needed above this limit must be deemed medically necessary through the AdSS's Prior Authorization (PA) process.

3. Preventive services, which include:

   a. Oral prophylaxis performed by a dentist or dental hygienist that includes self-care oral hygiene instructions to member, if able, or to the parent/legal guardian

   b. Application of topical fluorides

      The use of a prophylaxis paste containing fluoride or fluoride mouth rinses does not meet the AHCCCS standard for fluoride treatment.

c. Dental sealants for first and second molars (every three years up to 15 years of age, with a two-time maximum benefit)

Additional applications must be deemed medically necessary and require Prior Approval (PA) through the AdSS.

d. Space maintainers when posterior primary teeth are lost and when deemed medically necessary through the AdSS's PA process.

C. All therapeutic dental services, when they are considered medically necessary and cost effective, but they may be subject to PA by the AdSS (or the Division for AIHP members). These services include, but are not limited to:

1. Periodontal procedures, scaling/root planing, curettage, gingivectomy, and osseous surgery

2. Crowns:

a. When appropriate, stainless steel crowns may be used for both primary and permanent posterior teeth; composite, prefabricated stainless steel crowns with a resin window or crowns with esthetic coatings should be used for anterior primary teeth, or

b. Precious or cast semi-precious crowns may be used on functional permanent endodontically treated teeth, except third molars, for members who are 18 to 21 years of age.

3. Endodontic services including pulp therapy for permanent and primary teeth, except third molars (unless a third molar is functioning in place of a missing molar)

4. Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations, unless the member is 18 to 21 years of age and has had endodontic treatment

5. Restorations of anterior teeth for children under the age of five, when medically necessary

Children, five years and over with primary anterior tooth decay should be considered for extraction, if presenting with pain or severely broken down tooth structure, or be considered for observation until the point of exfoliation as determined by the dental provider.

6. Removable dental prosthetics, including complete dentures and removable partial dentures.

7. Orthodontic services and orthognathic surgery, only when these services are necessary to treat a handicapping malocclusion.

Services must be medically necessary and determined to be the primary treatment of choice or an essential part of an overall treatment plan

developed by both the PCP and the dentist in consultation with each other. Orthodontic services are not covered when the primary purpose is cosmetic.

Examples of conditions that may require orthodontic treatment include the following:

a. Congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services

b. Trauma requiring surgical treatment in addition to orthodontic services

c. Skeletal discrepancy involving maxillary and/or mandibular structures.

Services or items furnished solely for cosmetic purposes are excluded from Division and AHCCCS coverage (9 A.A.C. 22, Article 2).

Provider Requirements

Informed consent is a process by which the dental provider advises the member/member's parent or legal guardian of the diagnosis, proposed treatment, and alternate treatment methods, with associated risks and benefits of each and the associated risks and benefits of not receiving treatment.

Consents for oral health treatment include:

A. A written consent for examination and/or any preventative treatment measure, which does not include an irreversible procedure, as mentioned below (this consent is completed at the time of initial examination and is updated at each subsequent six-month follow-up appointment)

B. A separate written consent for any irreversible, invasive procedure, including but not limited to dental fillings, pulpotomy.

In addition, both parties must review and sign a written treatment plan, as described below, with the member's parent or legal guardian receiving a copy of the complete treatment plan.

All providers must complete the appropriate consents and treatment plans for members eligible for the Division as listed above, in order to provide quality and consistent care in a manner that protects and is easily understood by the member and/or the member's parent or legal guardian. Consents and treatment plans must be in writing and signed/dated by both the provider and the member, or the member's parent or legal guardian, if the member is under 18 years of age or is 18 years of age or older and considered an incapacitated adult (as defined in A.R.S. § 14-5101). Providers must maintain completed consents and treatment plans in the member's chart, and these charts are subject to audit.

The Division (AIHP Members) and AdSS Requirements

The AdSS must:

A. Conduct annual outreach efforts to members receiving oral health care through school-based or mobile unit providers (in or out of network), to:

1. Ensure members are aware of their dental home provider and contact information.

2. Let members know when school-based or mobile unit providers are not accessible, they can receive ongoing-access to care through the dental home provider.

B. Conduct written member educational outreach related to dental home, importance of oral health care, dental decay prevention measures, recommended dental periodicity schedule, and other AdSS-selected topics at least once every 12 months. These topics may be addressed separately or combined into one written outreach material; however, each topic must be covered during the 12-month period.

C. Educate providers in the importance of offering continuously accessible, coordinated, family-centered care.

D. Develop processes to:

1. Ensure members are enrolled into a dental home by one year of age, to allow for an ongoing provision of comprehensive oral health care. This process should allow members the choice of dental providers from within the AdSS's provider network and provide members instructions on how to select or change a dental home provider. Members not selecting a dental home provider will be automatically assigned a provider by the AdSS.

2. Connect all members to a dental home before one year of age or upon assignment to the AdSS, informing members of selected or assigned dental home provider contact information and recommended dental visit schedule.

3. Monitor member participation with the dental home and provide outreach to members who have not completed visits as specified in the AHCCCS Dental Periodicity Schedule (AMPM Exhibit 431-1).

4. Develop, implement, and maintain a procedure to notify all members/ responsible parties of visits required by the AHCCCS EPSDT and Dental Periodicity Schedules (AMPM Exhibits 430-1 and 431-1). Processes other than mailings must be preapproved by the Division. This procedure must include notification to members or responsible parties regarding due dates of biannual (once every six months) dental visits. If a dental visit has not taken place, a second notice must be sent.

5. Monitor provider engagement related to scheduling and follow-up of missed appointments, to ensure care consistent with the recommended AHCCCS

Dental Periodicity Schedule (Exhibit 431-1) for assigned members.

E. Develop and implement processes to reduce no-show appointment rates for dental services.

F. Provide targeted outreach to those members who did not show for appointments.

The AdSS must encourage all providers to schedule the next dental screening at the current office visit, particularly for children 24 months of age and younger.

G. Require the use of the AHCCCS Dental Periodicity Schedules (Exhibit 431-1) by all contracted providers. The AHCCCS Dental Periodicity Schedule gives providers necessary information regarding timeframes in which age-related required screenings and services must be rendered by providers.

The Division and the Administrative Services Subcontractors Requirements for the Dental Annual Plan

Each AdSS must have a written Dental Annual Plan that:

- Addresses minimum requirements as specified in this policy
- Addresses the objectives of the AdSS's program that are focused on achieving Division requirements
- Incorporate monitoring and evaluation activities for these minimum requirements (see AMPM Exhibit 400-2C, Dental Annual Plan Checklist).

The AdSS must submit the Dental Annual Plan no later than December 15th to the Division's Healthcare Services Clinical Administrator through the Compliance Unit for review and approval (see AMPM Exhibit 400-1, Maternal and Child Health Reporting Requirements).

The written Dental Annual Plan must contain, at a minimum, the following:

A. Dental Narrative Plan – A written narrative description of all planned activities to address the AdSS's minimum requirements for dental services, as specified in this policy. The narrative description must also include the AdSS activities to identify member needs and coordination of care, as well as follow-up activities to ensure appropriate treatment is received in a timely manner.

B. Dental Work Plan Evaluation – An evaluation of the previous year's Work Plan to determine the effectiveness of strategies, interventions, and activities used toward meeting stated objectives.

C. Dental Work Plan that includes:

1. Specific measurable objectives

These objectives must be based on AHCCCS established Minimum Performance Standards as adopted by the Division. In cases where the Minimum Performance Standards have been met, other generally accepted

benchmarks that continue the Contractor's improvement efforts will be used (e.g., National Committee on Quality Assurance, Healthy People 2020 standards). The AdSS may also develop its own specific measurable goals and objectives aimed at enhancing the Dental program when Minimum Performance Standards have been met.

2. Strategies and specific measurable interventions to accomplish objectives (e.g., member outreach, provider education, and provider compliance with mandatory components of the Dental program)

3. Targeted implementation and completion dates of work plan activities

4. Assigned local staff position(s) responsible and accountable for meeting each established goal and objective

5. Identification and implementation of new interventions, continuation of or modification to existing interventions, based on analysis of the previous year's Work Plan Evaluation

6. Relevant policies and procedures, referenced in the Dental Annual Plan, submitted as separate attachments.