



<b>Chapter 400</b>	<b>Medical Policy for Maternal and Child Health</b>
410	Maternity Care Services
411	Women's Preventative Care Services
420	Family Planning
430	Early Periodic Screening, Diagnosis and Treatment Services

## 410 MATERNITY CARE SERVICES

REVISION DATE: 2/26/2016, 1/15/2016, 7/3/2015, 9/15/2014

EFFECTIVE DATE: June 30, 1994

REFERENCES: A.R.S. § 14-5101; AHCCCS Medical Policy Manual 400:410

### Pregnant Women's Program

The goal of maternity care services is to ensure that pregnant women receive timely and uninterrupted prenatal care from a qualified obstetrical provider. Prenatal care is arranged through the member's Primary Care Physician.

### Pregnancy Termination

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

- A. 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.
- B. The pregnancy is a result of incest.
- C. The pregnancy is a result of rape.
- D. 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:
  - 1. Creating a serious physical or behavioral health problem for the pregnant member
  - 2. Seriously impairing a bodily function of the pregnant member
  - 3. Causing dysfunction of a bodily organ or part of the pregnant member
  - 4. Exacerbating a health problem of the pregnant member, or
  - 5. Preventing the pregnant member from obtaining treatment for a health problem.

### Conditions, Limitations and Exclusions

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 (Exhibit 410-4)* and supporting clinical documentation to DDD.

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.

#### Additional Required Documentation

- A. 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.
- B. 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.

#### Additional Considerations Related to Use of Mifepristone

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:

- A. Mifepristone can be administered through 49 days of pregnancy
- B. If the duration of pregnancy is unknown or if ectopic pregnancy is suspected, ultrasonography should be used for confirmation.
- C. Any Intrauterine Device ("IUD") should be removed before treatment with Mifepristone begins.
- D. 400 mg. of Misoprostol must be given two days after taking Mifepristone unless a complete abortion has already been confirmed.
- E. Pregnancy termination by surgery is recommended in cases when Mifepristone and Misoprostol fail to induce termination of the pregnancy.

When Mifepristone is administered, the following documentation is also required:

- A. Duration of pregnancy in days,
- B. The date IUD was removed if the member had one,
- C. The date Mifepristone was given,
- D. The date Misoprostol was given, and
- E. Documentation that pregnancy termination occurred.

### Prior Authorization (PA)

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

- A. *The AHCCCS Certificate of Necessity for Pregnancy Termination (Exhibit 410-4);*
- B. *The AHCCCS Verification of Diagnosis by Contractor for Pregnancy Termination Request (Exhibit 410-5); and,*
- C. Any lab, radiology, consultation or other testing results that support the justification/necessity for pregnancy termination.

The subcontracted health plan 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 subcontracted health plan 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: 7/3/2015, 9/15/2014

EFFECTIVE DATE: June 30, 1994

Medicaid allows for the provision of Family Planning Services. The goal of Family Planning Services is to enable a member to make choices in both the timing and occurrence of pregnancies. This service is available through the member's Primary Care Provider (PCP) and is part of the services offered by the health plans. Division health plans are required to educate their Providers on the full scope of available family planning services and how members may obtain them.

## 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.)