MATERNITY CARE SERVICES

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 Coordinating. 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.
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
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.

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.

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.