MEDICAL POLICY MANUAL

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310-B BEHAVIORAL HEALTH SERVICES

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.A.C. R9- 22-210.01; AMPM Chapter 100, AMPM Exhibit 310-1

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

The Division covers behavioral health services (mental health and/or substance abuse services) for members eligible for ALTCS and the Division.

**Amount, Duration and Scope**

Covered behavioral health services include, but are not limited to:

A. Inpatient hospital services
B. Inpatient Behavioral Health facility services
C. Institution for mental disease with limitations (refer to AMPM Chapter 100)
D. Behavioral health counseling and therapy, including electroconvulsive therapy
E. Psychotropic medication
F. Psychotropic medication adjustment and monitoring
G. Respite care
   The combined total of short-term and/or continuous respite care cannot exceed 600 hours per benefit year.
H. Partial care (supervised day program, therapeutic day program and medical day program)
I. Behavior management (behavioral health home care training, behavioral health self-help/peer support)
J. Psychosocial rehabilitation (skills training and development, behavioral health promotion/education, psycho-educational services, ongoing support to maintain employment, and cognitive rehabilitation)
K. Screening, evaluation and assessment
L. Case management services
M. Laboratory, radiology, and medical imaging services for diagnosis and psychotropic medication regulation
N. Emergency and non-emergency medically necessary transportation
O. Behavioral health supportive home care services.
A provider is not required to obtain prior authorization for emergency services. Regarding emergency services, refer to AMPM Exhibit 310-1 for a reprint of A.A.C. R9- 22-210.01 that describes general provisions for responsible entities, payment and denial of payment, notification requirements and post-stabilization requirements.

The AdSS must ensure that any Behavioral Health entity/provider, that develops a Behavior Plan for a member, trains family members and all staff to implement the plan with fidelity.
310-D1   DENTAL SERVICES FOR MEMBERS 21 YEARS OF AGE AND OLDER

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 36-2907, A.R.S. § 14-5101; A.A.C. R9-22-207; AMPM 310-D2

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The Division contracts with AdSS and delegates the responsibility of implementing this policy. This policy establishes requirements for the provision of medically necessary dental services for members of the Division of Developmental Disabilities (Division) who are age 21 and older. (Dental services for members under 21 years of age are covered as specified in Division Medical Policy 431.)

The Division requires the AdSS to cover the following dental services provided by a licensed dentist for members who are 21 years of age or older:

A. Emergency dental services up to $1,000 per member per contract year (October 1st to September 30th) as a result of A.R.S. § 36-2907. The emergency dental services are described in Emergency Dental Services Coverage for Persons Age 21 Years and Older (below).

B. Medical and surgical services furnished by a dentist only to the extent such services may be performed under state law either by a physician or by a dentist and such services would be considered a physician service if furnished by a physician (A.A.C. R9-22-207).

C. These services must relate to treatment of a medical condition such as acute pain (excluding Temporomandibular Joint Dysfunction [TMJ] pain), infection, or fracture of the jaw. Covered services include a limited problem focused examination of the oral cavity, required radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate anesthesia and the prescription of pain medication and antibiotics. Diagnosis and treatment of TMJ is not covered except for reduction of trauma. Services described in this paragraph are not subject to the $1,000 adult emergency dental limit.

D. Exception for Transplant Cases

For members needing medically necessary dental services as a prerequisite to Division-covered organ or tissue transplantation, covered dental services are limited to the elimination of oral infections and the treatment of oral disease, which include dental cleanings, treatment of periodontal disease, medically necessary extractions and the provision of simple restorations. For purposes of this policy, a simple restoration means silver amalgam and/or composite resin fillings, stainless steel crowns or preformed crowns. The Division covers these services only after a transplant evaluation determines that the member is an appropriate candidate for organ or tissue transplantation. These services are not subject to the $1,000 adult emergency dental limit.

E. Exception for Cancer Cases

Prophylactic extraction of teeth in preparation for radiation treatment of cancer of
the jaw, neck or head is covered. These services are not subject to the $1,000 adult emergency dental limit.

**Emergency Dental Services Coverage for Persons Age 21 and Older**

Medically necessary emergency dental care and extractions are covered for persons age 21 years and older who meet the criteria for a dental emergency. A dental emergency is an acute disorder of oral health resulting in severe pain and/or infection due to pathology or trauma.

The following services and procedures are covered as emergency dental services:

1. Emergency oral diagnostic examination (limited oral examination – problem focused)
2. Radiographs and laboratory services, limited to the symptomatic teeth
3. Composite resin due to recent tooth fracture for anterior teeth
4. Prefabricated crowns, to eliminate pain due to recent tooth fracture only
5. Recementation of clinically sound inlays, onlays, crowns, and fixed bridges
6. Pulp cap, direct or indirect plus filling
7. Root canals and vital pulpotomies when indicated for the treatment of acute infection or to eliminate pain
8. Apicoectomy performed as a separate procedure, for treatment of acute infection or to eliminate pain, with favorable prognosis
9. Immediate and palliative procedures, including extractions if medically necessary, for relief of pain associated with an oral or maxillofacial condition
10. Tooth reimplantation of accidentally avulsed or displaced anterior tooth, with favorable prognosis
11. Temporary restoration which provides palliative/sedative care (limited to the tooth receiving emergency treatment)
12. Initial treatment for acute infection, including, but not limited to, periapical and periodontal infections and abscesses by appropriate methods
13. Preoperative procedures and anesthesia appropriate for optimal patient management
14. Cast crowns limited to the restoration of root canal treated teeth only.

Follow-up procedures needed to stabilize teeth due the emergency service are covered and subject to the $1,000 limit.
**Adult Emergency Dental Services Limitations for Persons age 21 Years and Older**

The following adult dental services are not covered:

A. Maxillofacial dental services provided by a dentist, except to the extent prescribed for the reduction of trauma, including reconstruction of regions of the maxilla and mandible.

B. Diagnosis and treatment of temporomandibular joint dysfunction, except for the reduction of trauma.

C. Routine restorative procedures and routine root canal therapy.

D. Treatment for the prevention of pulpal death and imminent tooth loss, except for non-cast fillings, crowns constructed from pre-formed stainless steel, pulp caps, and pulpotomies only for the tooth causing pain or in the presence of active infection.

E. Fixed bridgework to replace missing teeth.

F. Dentures.

**AdSS and FFS Program Responsibilities**

A. The Division requires the AdSS to provide at least the following:

1. Coordination of covered dental services for enrolled Division members.

2. Documentation of current valid contracts with dentists who practice within the AdSS service area(s).

3. Primary care provider to initiate member referrals to dentist(s) when the member is determined to need emergency dental services, or members may self-refer to a dentist when in need of emergency dental services.

4. Monitoring of the provision of dental services and reporting of encounter data to the Division.

5. Assurance that copies of adult emergency dental policies and procedures have been provided to contracted dentist(s).

B. The annual $1,000 adult emergency dental limit is member specific and remains with the member if the member transfers between AdSSs or between Fee-For-Service and an AdSS. Dental services provided within an IHS/638 facility are also subject to the $1,000 adult emergency dental limit. The AdSS or Tribal Case Manager transferring the member must notify the accepting entity regarding the current balance of the dental benefit. The relinquishing AdSS must use ALTCS Enrollment Transition Information (ETI) (DDD-1541A) and Division Medical Policy 520 for reporting dental benefit balance to the receiving AdSS.

1. All services are subject to retrospective review to determine whether they satisfy the criteria for a dental emergency. Services determined to not meet the criteria for a dental emergency are subject to recoupment.
2. The member is NOT permitted to “carry-over” unused benefit from one year to the next.

3. A year begins on October 1st and ends September 30th.

C. Prior authorization for emergency dental services is not required for members enrolled with either FFS or Managed Care.

**Notification Requirements for Charges to Members**

Emergency dental services of $1,000 per contract year are covered for Division members age 21 years and older. Billing of Division members for emergency dental services in excess of the $1000 annual limit is permitted only when the provider meets the requirements of A.A.C R9-22-702 (for acute members) and A.A.C. R9-28-701.10 (for ALTCS members).

In order to bill the member for emergency dental services exceeding the $1,000 limit, the provider must first inform the member in a way s/he understands, that the requested dental service exceeds the $1,000 limit and is not covered by the Division. Before providing the dental services that will be billed to the member, the provider must furnish the member with a document to be signed in advance of the service, stating that the member understands that the dental service will not be fully paid by the Division and that the member agrees to pay for the amount exceeding the $1,000 emergency dental services limit, as well as services not covered by the Division.

The member must sign the document before receiving the service in order for the provider to bill the member. It is expected that the document will contain information describing the type of service to be provided and the charge for the service.

**Facility and Anesthesia Charges**

The Division expects that in rare instances a member may have an underlying medical condition which necessitates that services provided under the emergency dental benefit be provided in an Ambulatory Service Center or an Outpatient Hospital and may require anesthesia as part of the emergency service. In those instances, the facility and anesthesia charges are subject to the $1,000 emergency dental limit.

Dentists performing General Anesthesia (GA) on members will bill using dental codes and the cost will count towards the $1,000 emergency dental limit.

Physicians performing GA on members for a dental procedure will bill medical codes and the cost will count towards the $1,000 emergency dental limit.

**Informed Consent**

Informed consent is a process by which the provider advises the member/guardian/designated representative of the diagnosis, proposed treatment and alternate treatment methods with associated risks and benefits of each, as well as the associated risks and benefits of not receiving treatment.

A. Informed consents for oral health treatment include:
1. A written consent for examination and/or any 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.

2. A separate written consent for any irreversible, invasive procedure (e.g., dental fillings, pulpotomies). In addition, a written treatment plan must be reviewed and signed by both parties, as described below, with the member/guardian/designated representative receiving a copy of the complete treatment plan.

B. All providers must complete the appropriate informed consents and treatment plans for Division members as listed above, in order to provide quality and consistent care, in a manner that protects and is easily understood by the member/guardian/designated representative. This requirement extends to all AdSS mobile unit providers. Consents and treatment plans must be in writing and signed/dated by both the provider and the patient, or patient’s representative, if under 18 years of age or is 18 years of age or older and considered an incapacitated adult (as specified in A.R.S. §14-5101). Completed consents and treatment plans must be maintained in the members’ chart and are subject to audit.
310-D2 ARIZONA LONG TERM CARE SYSTEM ADULT DENTAL SERVICES

EFFECTIVE DATES: October 1, 2019

This Policy applies the Division’s Administrative Services Subcontractors (AdSS). This Policy establishes requirements regarding the provision of medically necessary dental services for members in the Long Term Care Program.

Policy

In accordance with A.R.S. § 36-2939, Arizona Long Term Care System (ALTCS) members age 21 or older may receive medically necessary dental benefits up to $1,000 per member per contract year (October 1st to September 30th) for diagnostic, therapeutic and preventative care, including dentures. The dental policy for members under age 21 is specified in AdSS Medical Policy 430 (Early Periodic Screening, Diagnostic and Treatment Services).

Members are also eligible for services as specified in AdSS Medical Policy 310-D1 (Dental Services for Members 21 Years of Age and Older). The services described in AdSS Medical Policy 310-D1 do not count towards the ALTCS $1,000 limit.

A. AdSS Responsibilities

1. The AdSS provides at least the following:
   
a. Coordination of covered dental services for enrolled members;

b. Documentation of current valid contracts with dentists who practice within the AdSS service area(s);

c. Primary care provider to initiate member referrals to dentist(s) when the member is determined to be in need of dental services, or members may self-refer to a dentist when in need of dental services,

d. Monitoring of the provision of dental services and reporting of encounter data to the Division; and

e. Assurance that copies of dental policies and procedures have been provided to contracted dentist(s).

2. The annual dental benefit limit is member specific and remains with the member if the member transfers between Managed Care Organizations or between Fee-For-Service and Managed Care. It is the responsibility of the AdSS transferring the member to notify the receiving AdSS regarding the current balance of the dental benefit. The ALTCS Enrollment Transition Information (ETI) form, AMPM Policy 1620, Exhibit 1620-9 must be utilized for reporting an dental benefit balance. Dental services provided within an Indian Health Service (IHS) or 638 Tribal Facility are also subject to the ALTCS dental benefit $1,000 limit.
The member is not permitted to “carry-over” unused benefit from one contract year to the next.

Frequency limitations and services that require prior authorization apply.

The AdSS must refer to AdSS Medical Policy 431 (Oral Health Care (EPSDT-Age Members) for the Dental Uniform Prior Authorization List.

B. **Facility and Anesthesia Charges**

In rare instances a member may have an underlying medical condition which necessitates that services provided under the dental benefit be provided in an Ambulatory Service Center or an Outpatient Hospital and may require anesthesia. In those instances, the facility and anesthesia charges are subject to the $1,000 limit.

Dentists performing General Anesthesia (GA) on members will bill using dental codes and the cost will count towards the $1,000 limit.

Physicians performing GA on a patient for a dental procedure will bill medical codes and the cost will count towards the $1,000 limit.

C. **Informed Consent**

Informed consent is a process by which the provider advises the member/guardian/designated representative of the diagnosis, proposed treatment and alternate treatment methods with associated risks and benefits of each, as well as the associated risks and benefits of not receiving treatment.

1. Informed 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, etc. In addition, a written treatment plan must be reviewed and signed by both parties, as described below, with the member/guardian/designated representative receiving a copy of the complete treatment plan.

2. All providers must complete the appropriate informed consents and treatment plans for members as listed above, in order to provide quality and consistent care, in a manner that protects and is easily understood by the member/guardian/designated representative. This requirement extends to all AdSS mobile unit providers. Consents and treatment plans must be in writing and signed and dated by both the provider and the patient, or patient’s representative, if under 18 years of age or is 18 years of age or older and considered an incapacitated adult (as specified in A.R.S. § 14-
5101). Completed consents and treatment plans must be maintained in the members’ chart and are subject to audit.

D. **Notification Requirements for Charges to Members**

Providers must provide medically necessary services within the $1,000 dental benefit allowable amount. In the event that medically necessary services are greater than $1,000, the provider may perform the services as set forth in A.A.C. R9-28-701(10) and R9-22-702, after the following notifications take place.

In accordance with A.A.C. R9-28-701(10) and R9-22-702 (Charges to Members), the provider must inform/explain to the member both verbally and in writing, in the member’s primary language, that the dental service requested is not covered and exceeds the $1,000 limit. If the member agrees to pursue the receipt of services:

1. The provider must supply the member a document describing the service and the anticipated cost of the service.

2. Prior to service delivery, the member must sign and date a document indicating that he/she understands that he/she will be responsible for the cost of the service to the extent that it exceeds the $1,000 limit.
310–G  EYE EXAMINATIONS/OPTOMETRY SERVICES

EFFECTIVE DATE: October 1, 2019

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

Eye and optometric services are covered for members eligible for ALTCS when provided by qualified eye/optometry professionals within certain limits based on member age and eligibility.

Emergency eye care which meets the definition of an emergency medical condition is covered for all members eligible for ALTCS. For members who are 21 years of age or older treatment of medical conditions of the eye, excluding eye examinations for prescriptive lenses and the provision of prescriptive lenses, are covered. Vision examinations and the provision of prescriptive lenses are covered for members under the Early and Periodic Screening, Diagnosis and Treatment Program, and for adults when medically necessary following cataract removal. Refer to Division Medical Policy Manual, Chapter 400 for detailed information regarding coverage of eye exams and prescriptive lenses for children.

Cataract removal is covered for all members eligible for ALTCS. Cataract removal is a covered service when the cataract is visible by exam, ophthalmoscopic or slit lamp, and any of the following apply:

A. Visual acuity that cannot be corrected by lenses to better than 20/70 and is reasonably attributable to cataract

B. In the presence of complete inability to see posterior chamber, vision is confirmed by potential acuity meter reading

C. For the Division’s American Indian Health Plan (Fee-For-Service) members, who have corrected visual acuity between 20/50 and 20/70, a second opinion by an ophthalmologist to demonstrate medical necessity may be required. Refer to the Contractors regarding requirements for their enrolled members.

Cataract surgery is covered only when there is a reasonable expectation by the operating ophthalmic surgeon that the member will achieve improved visual functional ability when visual rehabilitation is complete.

Cataract surgeries are generally done on an outpatient basis, but an inpatient stay may be required due to the need for complex medical and nursing care, multiple ocular conditions or procedures, or the member's medical status. Admission to the hospital may be deemed safer due to age, environmental conditions, or other factors.

Other cases that may require medically necessary ophthalmic services include, but are not limited to:

A. Phacogenic Glaucoma

B. Phacogenic Uveitis.
310-I HOME HEALTH SERVICES

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.A.C. R9-10-1201 et seq.

This policy applies to:

- The Division of Developmental Disabilities (Division) and its Administrative Services Subcontractors (AdSS) and Qualified Vendors
- Fee-For-Services (FFS) Programs, including Tribal Arizona Long Term Care System (ALTCS), the American Indian Health Program (AIHP), and all FFS populations.

This policy does not apply to Federal Emergency Services (FES); for information regarding FES, see Division Medical Manual Chapter 1100. This policy establishes requirements regarding Home Health Services.

Definitions

A. Home Health Agency - A public or private agency or organization, or part of an agency or organization, that is licensed by the state and meets requirements for participation in Medicare, including the capitalization requirements under 42 CFR 489.28 [42 CFR 440.70].

B. Home Health Services - Nursing services, home health aide services, therapy services, and medical supplies, equipment, and appliances as described in 42 CFR 440.70, when provided to a member at his/her place of residence and on his/her physician’s orders as part of a written plan of care [42 CFR 440.70].

C. Place of Residence - A member’s place of residence, for home health services, does not include a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF/IID), except for home health services in an ICF/IID facility that are not required to be provided by the facility under subpart I of part 483. For example, a registered nurse may provide short-term care for a beneficiary in an intermediate care facility for Individuals with Intellectual Disabilities during an acute illness to avoid the beneficiary’s transfer to a nursing facility.

Policy

The Division covers medically necessary home health services provided in the member’s place of residence as a cost-effective alternative to hospitalization. Covered services, within certain limits, include: home health nursing visits, home health aide services, medically necessary medical equipment, appliances and supplies, and therapy services for Division members. Home health services are covered when ordered by the member’s treating physician.

ALTCS covers home health services for members receiving home and community based services. Refer to Division Medical Policy 1240-G for additional information.

A. Home Health Nursing and Home Health Aide Services
Home health nursing and home health aide services are provided on an intermittent basis as ordered by a treating physician.

B. Physical Therapy, Occupational Therapy, Speech Therapy, and Audiology Services

Physical therapy, occupational therapy, speech therapy, and audiology services provided by a licensed home health agency are covered for members as specified in Division Medical Policy 310-X.

C. Medical Equipment, Appliances and Supplies

Medical equipment, appliances, and supplies provided by a licensed home health agency are covered for members.

D. Face-to-Face Encounter Requirements

1. Face-to-face encounter requirements apply to FFS only.

2. For initiation of home health services, a face-to-face encounter between the member and practitioner that relates to the primary reason the individual requires home health services is required within no more than 90 days before or within 30 days after start of services.

3. The face-to-face encounter must be conducted by one of the following:
   a. The ordering physician
   b. A nurse practitioner or clinical nurse specialist working in collaboration with the physician in accordance with state law
   c. A certified nurse midwife as authorized by state law
   d. A physician assistant under the supervision of the ordering physician, or
   e. For members admitted to home health immediately after an acute or post-acute stay, the attending acute or post-acute physician.

4. The non-physician practitioner specified above who performs the face-to-face encounter must communicate the clinical findings of the face-to-face encounter to the ordering physician.

5. The clinical findings must be incorporated into a written or electronic document in the member's record.

6. Regardless of which practitioner performs the face-to-face encounter related to the primary reason that the individual requires home health services, the physician responsible for ordering the services must document the practitioner who conducted the encounter, the date of the encounter, and that the face-to-face encounter occurred within the required timeframes.

The face-to-face encounter may occur through telehealth.
310–J HOSPICE SERVICES

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. §§ 36-2907 and 2989, 42 CFR 418.20 and 70, Arizona’s Section 115(a) Medicaid Demonstration Extension.

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

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

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

A. Hospital
B. Nursing care institution
C. Freestanding hospice.

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

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

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

Definitions

The following definitions apply to Hospice Services:

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

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

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

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

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

Amount, Duration and Scope

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

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

The AdSS must notify the Division’s Health Care Services within five business days of any approval or denial of Hospice services. The AdSS must also notify the Support Coordinator that a referral has been made.

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

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

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

C. Dietary services, which include a nutritional evaluation and dietary counseling when necessary
D. Home health aide services

E. Homemaker services

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

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

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

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

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

J. Social services provided by a qualified social worker

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

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

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

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

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

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 32-801 through 871

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

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

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

B. Ancillary Services

Ancillary services include any or all of the following:
   1. Audiology services
   2. Chemotherapy
3. Dental surgery for members in the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT)

4. Dental surgery for members 21 years of age and older within limitations as described in Division Medical Policy 310-D

5. Dialysis

6. Laboratory services

7. Pharmaceutical services and prescribed drugs

8. Radiological and medical imaging services

9. Rehabilitation services including physical, occupational and speech therapies

10. Respiratory therapy

11. Behavioral health assessments, and behavioral health therapy (including electroconvulsive therapy)

12. Services and supplies necessary to store, process, and administer blood and blood derivatives

13. Total parenteral nutrition


**Limitations and Exclusions**

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

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

EFFECTIVE DATE: October 1, 2019  
REFERENCES: AMPM Chapter 400

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

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

A. Diphtheria-tetanus  
B. Influenza  
C. Pneumococcus  
D. Rubella  
E. Measles  
F. Hepatitis-B  
G. Pertussis, as currently recommended by the CDC or ACIP  
H. Zoster vaccine, for members 60 and older  
I. HPV vaccine, for females and males up to age 26 years. Covered immunizations for children are identified in AMPM Chapter 400.

Immunizations for passport or visa clearance are not covered.

The Division does not require prior authorization for medically necessary immunization services performed by Fee-For-Service providers.
310-P MEDICAL EQUIPMENT, MEDICAL APPLIANCES AND MEDICAL SUPPLIES

EFFECTIVE DATE: October 1, 2019

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The Division contracts with AdSS and delegates the responsibility of implementing this policy. The purpose of this policy is to outline requirements for coverage of medically necessary medical equipment, appliances and medical supplies. Medical equipment and appliances are often referred to as Durable Medical Equipment (DME).

Definitions

A. Medical Equipment and Appliances - Any item, appliance, or piece of equipment (pursuant to 42 CFR 440.70) that is not a prosthetic or orthotic, and meets all of the following requirements:
   1. Is customarily used to serve a medical purpose, and is generally not useful to a person in the absence of an illness, disability, or injury
   2. Can withstand repeated use
   3. Can be reusable by others or removable.

For purposes of this policy, the term “medical equipment” refers to both medical equipment and appliances.

B. Medical Supplies - Supplies are health care-related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness or injury [42 CFR 440.70].

C. Setting in Which Normal Life Activities Take Place - A setting other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

Coverage Guidelines

A. The AdSS must cover medically necessary medical equipment and medical supplies (including incontinence briefs), under the home health services benefit, that are suitable for use in any setting in which normal life activities take place, as explained in this policy, when the following conditions are met:
   1. Provided at the member’s place of residence
   2. Ordered by the member’s physician as a part of the plan of care and is reviewed by the physician annually
   3. Authorized as required by the Division or the AdSS.
B. Medical equipment and medical supplies cannot be limited to members who are homebound.

C. Related Services, Devices, and Requirements:
   1. Nursing and home health aide home health services
   2. Rehabilitation Therapies (Occupational, Physical and Speech)
   3. Orthotic and Prosthetic Devices
   4. Prior Authorization Requirements
   5. Institutional Services and Settings.

D. Examples of medically necessary medical supplies and medical equipment are:
   1. Medical supplies – incontinence briefs, surgical dressings, splints, casts and other consumable items, which are not reusable, and are designed specifically to meet a medical purpose
   2. Medical equipment – wheelchairs, walkers, hospital beds, and other durable items that are rented or purchased.

**Coverage Determinations**

A. Coverage of medical equipment is not restricted to the items covered as durable medical equipment in the Medicare program. Coverage of medical equipment and supplies cannot be contingent upon the member needing nursing or therapy services.

B. The AdSS make timely determinations of coverage. The AdSS must not refuse to render a timely determination based on the member’s dual eligibility status or the providers’ contract status with the AdSS.

C. The following must be used in determining coverage of medical equipment and medical supplies:
   1. Services must be determined to be medically necessary, cost effective, and federally and state reimbursable.
   2. Services must be provided at the member’s place of residence and on the member’s physician’s orders as part of a plan of care.
   3. The member’s need for medical equipment and supplies must be reviewed by a physician annually. The frequency of further physician review for the member’s continuing need for services is determined on a case-by-case basis based on the nature of the prescribed item.
D. Services must be authorized, set up, and maintained to maximize the member’s independence and functional level in the most appropriate setting in which normal activities take place other than a hospital, nursing facility, ICF/IID, or any other setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

E. The AdSS must ensure the provider network includes a choice of vendors for customized medical equipment and corrective appliances for members with special healthcare needs. The AdSS must include, in the contract with the vendor, timeliness standards for creation, repair and delivery of customized equipment and appliances. The AdSS must monitor the standards and take action when the vendor is found to be out of compliance.

F. Medical equipment may be purchased or rented only when there are no reasonable alternative resources from which the medically necessary medical equipment can be obtained at no cost. Additionally, the total expense of rental cannot exceed the purchase price of the item.

G. Rental fees must terminate no later than the end of the month in which the member no longer needs the medical equipment, or when the member is no longer eligible or enrolled with the AdSS, except during transitions as specified by the Division’s Chief Medical Officer or designee.

H. Reasonable repairs or adjustment of purchased medical equipment are covered when necessary to make the equipment serviceable and when the cost of the repair is less than the cost of rental or purchase of another unit.

**Incontinence Briefs**

A. Incontinence Briefs for Members 21 years of age and older

Incontinence briefs, including pull-ups and incontinence pads, are covered when necessary to treat a medical condition. The Division may require prior authorization.

For ALTCS members 21 years of age and older, incontinence briefs, including pull-ups and incontinence pads, are also covered as specified in A.A.C. R9-28-202 in order to prevent skin breakdown when all the following are met:

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

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

3. Incontinence briefs – including pull-ups and incontinence pads – do not exceed 180 in any combination per month, unless the prescribing physician presents evidence of medical necessity for more than 180 per month.

4. The member obtains incontinence briefs from vendors within the AdSS’s network.
5. Prior authorization has been obtained as appropriate. AdSS must not require a new prior authorization to be issued more frequently than every 12 months.

B. Incontinence Briefs for Members under the Age of 21 Years
   a. AHCCCS covers incontinence briefs when necessary to treat a medical condition.
   b. In addition, AHCCCS also covers incontinence briefs for preventative purposes for members over the age of three and under 21 years of age as described in Division Medical Policy Manual, Policy 430 and A.A.C. R9-22-212.

**Limitations**

A. Except for incontinence briefs as specified in this policy, personal care items including items for personal cleanliness, body hygiene, and grooming are not covered unless needed to treat a medical condition.

B. First aid supplies are not covered unless they are provided in accordance with a prescription.
310-R  NURSING FACILITY SERVICES

EFFECTIVE DATE: October 1, 2019

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The Division of Developmental Disabilities (Division) covers medically necessary services rehabilitative services provided in Nursing Facilities (NF) for members who are eligible for Arizona Long Term Care System (ALTCS) with acute medical needs and who need nursing care 24 hours a day but who do not require hospital care under the daily direction of a physician. NF service providers must be state licensed and Medicare certified. Religious nonmedical health care institutions are exempt from licensure or certification requirements. Prior to a denial of NF services, the AdSS must contact the Division for a second level review.

See Chapter 1210 of this manual regarding Institutional Services for members who are ALTCS eligible.

The Division covers services for members who have acute medical needs and are eligible for ALTCS. The following requirements apply:

A. The medical condition of the member must be such that if NF services are not provided, hospitalization of the individual will result or the treatment is such that it cannot be administered safely in a less restrictive setting (i.e., home with home health services). While convalescent care should be considered short-term, the Contractor shall extend NF coverage as medically necessary. The AdSS must contact the Division by Day 45 of the member's placement to discuss long term placement alternatives and coordinate discharge planning with the Division. Prior to consideration of long term NF placement as outlined in Chapter 1210 of this manual, the AdSS must obtain approval from the Division.

B. For members enrolled in the ALTCS Transitional Program whose health status indicates that the member will likely require NF placement for longer than 90 days, the AdSS shall provide notification to the Division's assigned Support Coordinator. The Support Coordinator shall notify AHCCCS for consideration of continued enrollment in the Transitional Program or a change to ALTCS status.

Services that are not covered separately when provided in an NF include:

A. Nursing services, including:
   1. Administration of medication
   2. Tube feedings
   3. Personal care services
   4. Routine testing of vital signs and blood glucose monitoring
   5. Assistance with eating
B. Basic patient care equipment and sickroom supplies such as bedpans, urinals, diapers, bathing and grooming supplies, walkers and wound dressings or bandages

C. Dietary services including, but not limited to, preparation and administration of special diets, and adaptive tools for eating

D. Administrative physician visits made solely for meeting state certification requirements

E. Non-customized durable equipment and supplies such as manual wheelchairs, geriatric chairs, and bedside commodes

F. Rehabilitation therapies ordered as a maintenance regimen

G. Administration, Medical Director Services, plant operations, and capital

H. Over-the-counter medications and laxatives

I. Social activity, recreational and spiritual services

J. Any other services, supplies or equipment that are state or county regulatory requirements or are included in the NF’s room and board charge.
310-V  PRESCRIPTION MEDICATION/PHARMACY SERVICES

EFFECTIVE DATE: October 1, 2019


This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The Division covers medically necessary, cost effective, and federally and state reimbursable medications prescribed by a physician, physician’s assistant, nurse practitioner, dentist, or other AHCCCS-registered practitioner, and dispensed by an Arizona Health Care Cost Containment System (AHCCCS)-registered licensed pharmacy, for members consistent with A.A.C. R9-22-201 et seq., R9-28-201 et seq., and R9-31-201 et seq. and for persons who have a diagnosis of Serious Mental Illness, pursuant to ARS § 36-550. At a minimum, items listed in the Division’s Formulary must be included as covered benefits for members who are eligible for ALTCS.

Psychotropic drugs for behavioral health symptoms must be covered according to AHCCCS Rules.

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

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

Definitions

A.  Adverse Drug Event (ADE) - An injury resulting from medical intervention related to a drug including harms that occur during medical care that are directly caused by the drug including but not limited to medication errors, adverse drug reactions, allergic reactions, and overdose.

B.  AHCCCS Behavioral Health Drug List - A list of preferred behavioral health medications that are to be used by all contractors responsible for the administration of behavioral health pharmacy benefits, including but not limited to Long Term Care, Children's Rehabilitative Services, and RBHAs, which are. This drug list is limited to federally and state reimbursable behavioral health medications that are supported by current evidence-based medicine. The AHCCCS Behavioral Health Drug List was developed to encourage the use of safe, effective, clinically appropriate, and the most cost-effective behavioral health medications.

C.  AHCCCS Drug List - A list of preferred drugs used by all contractors responsible for the administration of acute and long-term care pharmacy benefits. This drug list identifies specific federally and state reimbursable medications and related products, which are supported by current evidence-based medicine. The AHCCCS Drug List was developed to encourage the use of safe, effective, clinically appropriate, and the most cost-effective medications.
D. AHCCCS Drug Lists – Refers to both the AHCCCS Drug List and the AHCCCSS Behavioral Health Drug List

E. Biosimilar - A biological drug approved by the FDA based on a showing that it is highly similar to an FDA-approved biological drug, known as the reference product, and has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

F. Generic Drug - A drug that contains the same active ingredient(s) as a brand name drug and the FDA has approved it to be manufactured and marketed after the brand name drugs patent expires. Generic drug substitution must be completed in accordance with Arizona State Board of Pharmacy rules and regulations.

G. Medication Error - The inappropriate use of a drug that may or may not result in harm; such errors may occur during prescribing, transcribing, dispensing, administering, adherence, or monitoring of a drug.

H. Non-Preferred Drug - A medication that is not listed on the AHCCCS Drug List or the AHCCCS Behavioral Health Drug List. Non-Preferred drugs require prior authorization.

I. Pharmacy and Therapeutics (P&T) Committee - The advisory committee to the AHCCCS Administration, which is responsible for developing, managing, updating, and administering the AHCCCS Drug List and AHCCCS Behavioral Health Drug List. The P&T Committee is primarily comprised of physicians, pharmacists, nurses, and other health care professionals.

J. Preferred Drug - A medication that has been clinically reviewed and approved by the AHCCCS P&T Committee for inclusion on the AHCCCS Drug List and/or the AHCCCS Behavioral Health Drug List as a preferred drug due to its proven clinical efficacy and cost effectiveness.

K. Serious Mental Illness (SMI) - A diagnosis of, a condition defined in A.R.S. § 36-550 and diagnosed in a person 18 years of age or older.

L. Step Therapy – The practice of initiating drug therapy for a medical condition with the most cost-effective and safest drug, and stepping up through a sequence of alternative drug therapies as a preceding treatment option.

**Drug Lists**

Each AdSS must maintain its own drug list to meet the unique needs of the members they serve. At a minimum, the AdSS’s drug list must include all drugs listed on the AHCCCS Drug Lists.

The AHCCCS Drug Lists are not all-inclusive lists of medications. AdSSs must cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable regardless of whether these medications are included on these lists.
A. Preferred Drugs

The Division and its Administrative Services Subcontractors (AdSSs) must maintain preferred drug lists which include each and every drug exactly as listed on the AHCCCS Drug List and/or the AHCCCS Behavioral Health Drug List, as applicable. When the AHCCCS Drug List and/or AHCCCS Behavioral Health Drug List specify a preferred drug(s) in a particular therapeutic class, the Division and AdSSs are not permitted to add other preferred drugs to their preferred drug lists in those therapeutic classes.

The Division and AdSSs must inform their Pharmacy Benefit Managers (PBM) of the preferred drugs and must require the PBM to institute point-of-sale edits that communicate back to the pharmacy the preferred drug(s) of a therapeutic class whenever a claim is submitted for a non-preferred drug. Preferred drugs recommended by the AHCCCS P&T Committee and approved by AHCCCS will become effective on the first day of the first month of the quarter following the P&T Meeting unless otherwise communicated by AHCCCS.

AdSSs must approve the preferred drugs listed for the therapeutic classes contained on the AHCCCS Drug List and/or the AHCCCS Behavioral Health Drug List, as appropriate, before approving a non-preferred drug, unless:

a. The member has previously completed step therapy using the preferred drug(s), or

b. The member’s prescribing clinician supports the medical necessity of the non-preferred drug over the preferred drug for the particular member.

The Division and AdSSs are not required to provide a Notice of Adverse Benefit Determination when the prescribing clinician is in agreement with the change to the preferred drug. A prior authorization request may be submitted for the non-preferred drug when the prescribing clinician is not in agreement with transition to the preferred drug. The Division and AdSSs must issue a Notice of Adverse Benefit Determination in accordance with Division Operations Manual Policy 414 for Service Authorizations when a prior authorization request is denied or a previously approved authorization is terminated, suspended, or reduced.

B. Grandfathering of Non-preferred Drugs

Grandfathering of non-preferred drugs refers to the continued authorization of non-preferred drugs for members who are currently using non-preferred drugs without having completed step therapy of the preferred drug(s) on the AHCCCS Drug List and/or the AHCCCS Behavioral Health Drug List, as appropriate.

The AHCCCS P&T Committee makes recommendations to AHCCCS on the grandfathering status of each non-preferred drug for each therapeutic class reviewed by the committee. When the status of a non-preferred drug is changed and has been approved for grandfathering, the Division and AdSSs must grandfather members on these medications.
C. Prior Authorization

1. The AHCCCS Behavioral Health Drug List

The Division uses the AHCCCS Behavioral Health Drug List, which specifies the medications that require Prior-Authorization (PA). The Division and AdSSs must apply the same PA criteria as those specified on the AHCCCS website for medications listed on the AHCCCS Behavioral Health Drug List that require prior authorization prior to dispensing the medication. When a medication on the AHCCCS Behavioral Health Drug List is subject to PA but no PA criteria are specified, the Division and AdSSs may elect to establish PA criteria based on clinical appropriateness, scientific evidence, and standards of practice that include, but are not limited to, all of the following:

   a. Food and Drug Administration (FDA) approved indications and limits
   b. Published practice guidelines and treatment protocols
   c. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes
   d. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies
   e. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up To Date).

The Division and AdSSs are prohibited from adding prior authorization and/or step therapy requirements to medications listed on the AHCCCS Behavioral Health Drug List when the list does not specify these requirements.

For those behavioral health medications that are non-preferred drugs and not listed on the AHCCCS Behavioral Health Drug List, the Division and AdSSs must evaluate the submitted prior authorization request on an individual basis.

All federally and state reimbursable drugs that are not listed on the AHCCCS Behavioral Health Drug List or AdSSs’ drug lists must be available through the prior authorization process.

2. The AHCCCS Drug List

The Division and AdSSs administering the pharmacy benefit using the AHCCCS Drug List are responsible for establishing prior authorization criteria for medications which require prior authorization as identified on the AHCCCS Drug List with the exception of Smoking Cessation medications and Direct Acting Antiviral Hepatitis C medications. The Division and AdSSs must follow the criteria developed by AHCCCS for Smoking Cessation medications and for Direct Acting Antiviral Hepatitis C medications.
For all other medications subject to PA, the Division and AdSSs may elect to establish PA criteria based on clinical appropriateness, scientific evidence, and standards of practice, that include, but are not limited, to all of the following:

a. FDA approved indications and limits
b. Published practice guidelines and treatment protocols
c. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes
d. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies
e. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up To Date).

In addition, for medications that are non-preferred drugs and not listed on the AHCCCS Drug List, the Divisions and AdSSs must evaluate the submitted prior authorization request on an individual basis.

The Division and AdSSs must not add prior authorization and/or step therapy requirements to medications listed on the AHCCCS Drug List when the list does not identify the medication as being subject to prior authorization or step therapy.

**All federally and state reimbursable drugs that are not listed on the AHCCCS Drug List or contractors’ drug lists must be available through the prior authorization process.**

A medication must not be denied solely due to the lack of a FDA indication. Off-label prescribing may be clinically appropriate as outlined above in C.2.b through e.

The Division and AdSSs must cover medically necessary federally and state reimbursable behavioral health medications for persons who are Title XIX, Title XXI, and for persons who are SMI, regardless of whether or not they are eligible for Title XIX. It is not a basis to deny coverage of a medically necessary medication when the member’s insurer, other than Medicare Part D, refuses to approve the request or appeal for a medication listed on the AHCCCS Behavioral Drug List.

**D. Requests for Changes to the AHCCCS Drug**

Requests for medication additions, deletions or other changes to the AHCCCS Drug Lists must be reviewed by the AHCCCS P&T Committee. Requests must be submitted no later than 60 days prior to the AHCCCS P&T Meeting to the AHCCCS Pharmacy Department email at: AHCCCSPharmacyDept@azahcccs.gov
The request must include all of the following information:

a. Name of medication requested (brand name and generic name)
b. Dosage forms, strengths and corresponding costs of the medication requested
c. Average daily dosage
d. FDA indication and accepted off-label use
e. Advantages or disadvantages of the medication over currently available products on the AHCCCS Drug List
f. Adverse Drug Events reported with the medication
g. Specific monitoring requirements and costs associated with these requirements
h. A detailed clinical summary.

E. Quantity Limits/Step Therapy

For all preferred drugs on the AHCCCS Drug List and the AHCCCS Behavioral Health Drug List, the contractor must adopt the quantity limits and step therapy requirements exactly as presented in the AHCCCS Drug List and the AHCCCS Behavioral Health Drug List.

Step Therapy programs apply coverage rules at the point of service when a claim is adjudicated. If a claim is submitted for a second-line drug, which is a medication that is not the first drug normally used to treat a condition, the claim will reject. A message is transmitted to the pharmacy stating that the first-line drug treatment must be tried before coverage of the second-line drug can be authorized unless there is a clinical justification for not using the first line drug.

The Division and AdSSs are not required to provide a Notice of Adverse Benefit Determination when the prescribing clinician is in agreement with the change to the first-line drug. A prior authorization may be submitted for the second-line drug when the prescribing clinician is not in agreement with the transition request to the first-line drug. The Division and AdSSs must issue a Notice of Adverse Benefit Determination in accordance with Division Policy for Service Authorizations when a prior authorization request is denied, or a previously approved authorization is terminated, suspended, or reduced.
F. Generic and Biosimilar Drug Substitutions

1. The Division and AdSSs must use a mandatory generic drug substitution policy that requires the use of a generic equivalent drug whenever one is available. The exceptions to this requirement are:
   a. A brand name drug may be covered when a generic equivalent is available when the contractor’s negotiated rate for the brand name drug is equal to or less than the cost of the generic drug.
   b. AHCCCS may require the Division and AdSSs to provide coverage of a brand name drug when the cost of the generic drug has an overall negative financial impact to the state. The overall financial impact to the state includes consideration of the federal and supplemental rebates.

2. Prescribing clinicians must clinically justify the use of a brand-name drug over the use of its generic equivalent through the prior authorization process.

3. Generic and biosimilar substitutions must adhere to Arizona State Board of Pharmacy rules and regulations.

4. The Division and AdSSs must not transition to a biosimilar drug until AHCCCS has determined that the biosimilar drug is overall more cost-effective to the state than the continued use of the brand name drug.

G. Behavioral Health Medication Coverage

1. Behavioral Health Medications Prescribed by the Primary Care Provider (PCP) for the Treatment of Anxiety, Depression and Attention Deficit Hyperactivity Disorder (ADHD)

   The Division and AdSSs must provide coverage for medically necessary, cost-effective, and federally and state reimbursable behavioral health medications prescribed by a PCP when used to treat depression (including postpartum depression), anxiety and ADHD; this includes the monitoring and adjustments of behavioral health medications.

2. Behavioral Health Medication Coverage for AHCCCS Members Transitioning from a Behavioral Health Medical Professional (BHMP) to a PCP.

   Members transitioning from a BHMP to a PCP for their behavioral health medication management must be continued on the medication(s) prescribed by the BHMP until they transition to their PCP. The Division and AdSS must coordinate the care and ensure that the member has a sufficient supply of behavioral health medications to last through the date of the member’s first appointment with their PCP. Members receiving behavioral health medications from their PCP may simultaneously receive counseling and other medically necessary services from the TRBHA.
H. Over-The-Counter Medication

The Division and AdSSSs may cover an over-the-counter medication under the pharmacy benefit when it is prescribed in place of a covered prescription medication that is clinically appropriate, equally safe and effective, and more cost effective than the covered prescription medication.

I. Prescription Drug Coverage Limitations

1. A new prescription or refill prescription in excess of a 30-day supply or a 100-unit dose is not covered, unless any of the following apply:

   a. The medication is prescribed for a chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit dose, whichever is greater.

   b. The member will be out of the provider’s service area for an extended period of time and the prescription is limited to the extended time period, not to exceed 100 days or 100-unit dose, whichever is greater.

   c. The medication is prescribed for contraception and the prescription is limited to no more than a 100-day supply.

2. Prescription drugs for covered transplantation services will be provided in accordance with AHCCCS transplantation policies.

J. Prior Authorization (PA) Requirements for Long-Acting Opioid Medications

PA is required for all prescriptions for long-acting opioid medications. The prescriber must obtain PA for all prescriptions for long-acting opioid medications from the Division.

K. 5-Day Supply Limit of Prescription Opioid Medications-Contractor Requirements

1. Members under 18 years of age

   a. Except as otherwise specified in Section K(1)(b), Conditions and Care Exclusion from the 5-day Supply Limitation of this policy, a prescriber must limit the initial and refill prescriptions for any short-acting opioid medication for a member under 18 years of age to no more than a 5-day supply.

   An initial prescription for a short-acting opioid medication is one in which the member has not previously filled any prescription for a short-acting opioid medication within 60 days of the date of the pharmacy filling the current prescription as evidenced by the member’s Pharmacy Benefit Management (PBM) prescription profile.
b. Conditions and Care Exclusion from the 5-day Supply Limitation

i. The initial and refill prescription 5-day supply limitation for short-acting opioid medications does not apply to prescriptions for the following conditions and care instances:

- Active oncology diagnosis
- Hospice care
- End-of-life care (other than hospice)
- Palliative care
- Children on opioid wean at time of hospital discharge
- Skilled nursing facility care
- Traumatic injury, excluding post-surgical procedures
- Chronic conditions for which the provider has received PA approval from the Division.

ii. The initial prescription 5-day supply limitation for short-acting opioid medications does not apply to prescriptions for post-surgical procedures. However, initial prescriptions for short-acting opioid medications for post-surgical procedures are limited to a supply of no more than 14 days. Refill prescriptions for short-acting opioid medications for post-surgical procedures are limited to no more than a 5-day supply.

2. Members 18 years of age and older

a. Except as otherwise specified in Section K(2)(b), Conditions and Care Exclusion from the 5-day Supply Limitation of this policy, a prescriber must limit the initial prescription for any short-acting opioid medication for a member 18 years of age and older to no more than a 5-day supply.

An initial prescription for a short-acting opioid medication is one in which the member has not previously filled any prescription for a short-acting opioid medication within 60 days of the date of the pharmacy filling the current prescription as evidenced by the member’s Pharmacy Benefit Management (PBM) prescription profile.
b. Conditions and Care Exclusion from the 5-day Initial Supply Limitation

The **initial** prescription 5-day supply limitation for short-acting opioid medications does not apply to prescriptions for the following conditions and care instances:

i. Active oncology diagnosis
ii. Hospice care
iii. End-of-life care (other than hospice)
iv. Palliative care
v. Skilled nursing facility care
vi. Traumatic injury, excluding post-surgical procedures
vii. Post-surgical procedures. Initial prescriptions for short-acting opioid medications for post-surgical procedures are limited to a supply of no more than 14 days.

L. AHCCCS Pharmacy Benefit Exclusions

The following are excluded from the pharmacy benefit:

1. Medication prescribed for the treatment of a sexual or erectile dysfunction, unless:
   a. The medication is prescribed to treat a condition other than a sexual or erectile dysfunction
   b. The Food and Drug Administration has approved the medication for the specific condition.

2. Medications that are personally dispensed by a physician, dentist, or other provider except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.

3. Drugs classified as Drug Efficacy Study Implementation (DESI) drugs by the Food and Drug Administration

4. Outpatient medications for members under the Federal Emergency Services Program

5. Medical Marijuana (refer to Division Medical Policy Manual, Policy 320-M in this manual)

6. Drugs eligible for coverage under Medicare Part D for AHCCCS members eligible for Medicare whether or not the member obtains Medicare Part D coverage
7. Experimental medications
8. Automatically refilled prescriptions.

Pharmacies are prohibited from auto-filling prescription medications.

M. Return of and Credit for Unused Medications

The Division and AdSSs must require the return of unused medications to the outpatient pharmacy from Nursing Facilities (NFs) upon the discontinuance of prescriptions due to the transfer, discharge, or death of a member. A payment/credit reversal must be issued for unused prescription medications by the outpatient pharmacy to the AHCCCS Administration or the appropriate AHCCCS contractor. The pharmacy may charge a reasonable restocking fee as agreed upon with the AHCCCS Administration and its contractors. The return of unused prescription medication must be in accordance with federal and state laws. A.A.C. R4-23-409 allows for this type of return and the redistribution of medications under certain circumstances. Documentation must be maintained and must include the quantity of medication dispensed and used by the member. A credit must be issued to the AHCCCS Administration, if the member is enrolled in the American Indian Health Plan/TRBHA/Fee-For-Service (AIHP/FFS) Program, or to the member’s contractor for members who are not FFS when the unused medication is returned to the pharmacy for redistribution.

N. Discarded Physician-Administered Medications

Discarded federally and state reimbursable physician-administered medications must not be billed to the Division or its contractors. A.A.C. R9-22-209(C) provides that pharmaceutical services are covered only if they are prescribed. The unused portion of a physician administered drug is not covered because it is not medically necessary or prescribed.

A.R.S. §36-2918(A)(1) prohibits a person from making a claim for an item or service that the person knows or has reason to know was not provided as claimed.

A.R.S. §36-2918(A)(3)(b) prohibits a person from submitting a claim for items and services that substantially exceed the needs of the patient.

O. Prior Authorization Criteria for Smoking Cessation Aids


P. Prior Authorization Criteria for Direct Acting Antiviral Treatment for Hepatitis C

See Division Medical Policy Manual, Policy320-N.

Q. Vaccines and Emergency Medications Administered by Pharmacists to Persons Age 18 Years and Older

Vaccines and emergency medication are covered, without a prescription order when administered by a pharmacist who is currently licensed and certified by the Arizona
State Board of Pharmacy consistent with the limitations of this policy and state law A.R.S. § 32-1974.

1. For purposes of this section “Emergency Medication” means emergency epinephrine and diphenhydramine. “Vaccines” are limited to pneumococcal and influenza vaccines.

2. The pharmacy providing the vaccine must be an AHCCCS-registered provider. Indian Health Service and 638 facilities may bill the outpatient all-inclusive rate for pharmacist vaccine administration as noted in Section L of this policy.

3. Contractors retain the discretion to determine the coverage of vaccine administration by pharmacists and coverage is limited to the Division and AdSS’s network pharmacies.

R. 340B Reimbursement

A.A.C. R9-22-710 (C) describes the reimbursement methodology to be used by AHCCCS and its contractors for Federally Qualified Health Center (FQHC) and FQHC Look-Alike Pharmacies for 340B drugs as well as reimbursement for Contract Pharmacies that have entered into a 340B drug purchasing arrangement with any 340B entity. The Rule also specifies reimbursement for FQHC and FQHC Look-Alike Pharmacies for drugs, which are not part of the 340B Drug Pricing program. This rule is located on the AHCCCS Website.

S. Pharmaceutical Rebates

The contractor, including the contractor’s PBM, is prohibited from negotiating any rebates with drug manufacturers for preferred or other pharmaceutical products when AHCCCS has a supplemental rebate contract for the product(s). A listing of products covered under supplemental rebate agreements will be available on the AHCCCS website under the Pharmacy Information section. If the contractor or its PBM has an existing rebate agreement with a manufacturer, all outpatient drug claims, including provider-administered drugs for which AHCCCS is obtaining supplemental rebates, must be exempt from such rebate agreements.

T. Informed Consent

Informed consent must be obtained from the member and/or legal guardian for each psychotropic medication prescribed. The comprehensive clinical record must include documentation of the essential elements for obtaining informed consent. Essential elements for obtaining informed consent for medication are contained within this policy manual. 310-V-Attachment A is recommended as a tool to document informed consent for psychotropic medications.
310-DD COVERED TRANSPLANTS AND RELATED IMMUNOSUPPRESSANT MEDICATIONS

EFFECTIVE DATE: October 1, 2019

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The Division contracts with AdSS and delegates the responsibility of implementing this policy.

Federal law 42 U.S.C. 1396b (i) and 42 CFR 441.35 describe general requirements for Title XIX coverage of transplants. For adults, organ transplant services are not mandatory covered services under Title XIX, and each state has the discretion to choose whether or not transplants will be available to members. The AHCCCS Administration, as the single state agency, has the authority under federal law to determine which transplant procedures, if any, will be reimbursed as covered services.

In contrast to transplant coverage for persons age 21 years and older, the Early and Periodic Screening Diagnostic and Treatment (EPSDT) Program for individuals under age 21 covers all non-experimental transplants necessary to correct or ameliorate defects, illnesses and physical conditions. Transplants members under age 21 eligible ALTCS Program are covered when medically necessary irrespective of whether or not the particular non-experimental transplant is specified as covered in the AHCCCS State Plan.

The Division covers the specific medically necessary transplantation services and related immunosuppressant medications as described in this policy.

The solid organ and tissue transplant services described in this policy, including the relevant standards of coverage, are referenced in the AHCCCS State Plan. The AHCCCS State Plan is the document approved by the federal government which outlines the eligibility requirements and covered services for the AHCCCS program.

Transplants must be medically necessary, cost effective, federally reimbursable, and state reimbursable. Arizona State laws and regulations specifically address transplant services and related topics, as follows:

A. Specific non-experimental transplants approved for Title XIX reimbursement are covered services (A.R.S. §36-2907).
B. Services which are experimental, or which are provided primarily for the purpose of research are excluded from coverage (A.A.C. R9-22-202).
C. Medically necessary is defined as those covered services “provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability or other adverse health conditions, or their progression, or prolong life” (A.A.C. R9-22-101).
D. Experimental services are as described in R9-22-203.
E. Standard of care is defined as “a medical procedure or process that is accepted as treatment for a specific illness, injury or medical condition through custom, peer review or consensus by the professional medical community” (A.A.C. R9-22-101).

F. The AHCCCS Administration consulted with transplant experts to identify criteria for transplant coverage consistent with the current body of medical literature, including United Network for Organ Sharing (UNOS) clinical standards for solid organ transplant procedures, the Foundation for the Accreditation of Cellular Therapy (FACT) and peer-reviewed articles in medical journals published in the United States.

G. For persons ages 21 years and older, transplantation coverage is limited to the specific transplant types set forth in this policy. All other transplant types for persons ages 21 years and older are excluded from AHCCCS reimbursement. This policy includes criteria, indications and relative contraindications and absolute contraindications for each covered transplant type. Unless a contraindication is explicitly described as an absolute contraindication, the contraindication is a relative contraindication. However, these may change as a result of advances in medical treatment and technological innovation. The presence of an absolute contraindication precludes authorization for a transplant.

H. The AdSS must consult current authoritative medical sources to determine whether a transplant covered under this policy is medically necessary, cost-effective, non-experimental, and not primarily for purposes of research. The AdSS must provide the medical justification for the decision that is made. The AdSS has access to and may consult with the transplantation management entity (AHCCCS consultant) under contract with AHCCCS. Although the AdSS is encouraged to consult with the AHCCCS consultant for guidance in those cases requiring such medical determinations, the AdSS is not required to do so. AdSSs not using the AHCCCS consultant must obtain their own expert opinion.

Definitions

A. Absolute Contraindication – A condition or circumstance that if present precludes authorization of a transplant regardless of any other considerations.

B. Close Proximity - means within the geographic service area.

C. Emergent Fulminant Hepatic/Liver Failure - Liver failure that occurs suddenly in a previously healthy person. The most common causes are acute hepatitis, acetaminophen overdose, and liver damage from prescription drugs.

D. Experimental service – Refer to AHCCCS Rule R9-22-203. This rule provides, in part: Experimental services are not covered. A service is not experimental if:

1. It is generally and widely accepted as a standard of care in the practice of medicine in the United States and is a safe and effective treatment for the condition for which it is intended or used.

2. The service does not meet the standard in (1), but the service has been demonstrated to be safe and effective for the condition for which it is
intended or used based on the weight of the evidence in peer-reviewed articles in medical journals published in the United States.

3. The service does not meet the standard in (2) because the condition for which the service is intended or used is rare, but the service has been demonstrated to be safe and effective for the condition for which it is intended or used based on the weight of opinions from specialists who provide the service or related services.

E. Hematopoietic Stem Cell Transplants (HSCT) - The transplantation of blood stem cells derived from the bone marrow or peripheral blood, including cord blood. Conditioning therapy includes either myeloablative or non-myeloablative induction with or without Total Body Irradiation (TBI).

F. Relative Contraindications – A condition or circumstance that must be considered on a case-by-case basis to determine if a transplant will be authorized.

Description of Policy

This policy sets forth criteria, including indications and contraindications, for determining whether transplant services are medically necessary, cost effective, non-experimental, and not primarily for purposes for research. Contraindications are conditions which may significantly adversely impact the outcome of the transplant. They are not regarded as an absolute bar to transplantation. Contraindications must be evaluated along with all other relevant factors to determine whether the transplant service is medically necessary, non-experimental, and not primarily for purposes of research in each particular case.

The AdSS must consult with the Division’s Medical Director prior to denying the authorization for transplant of the heart, heart/lung, and liver.

Transplant Services and Settings

Transplant services are covered only when performed in specific settings:

A. Solid organ transplantation services must be provided in a CMS certified and UNOS approved transplant center which meets the Medicare conditions for participation and special requirements for transplant centers delineated in 42 CFR Part 482.

B. Hematopoietic stem cell transplant services must be provided in a facility that has achieved Foundation for the Accreditation of Cellular Therapy (FACT) accreditation. The facility must also satisfy the Medicare conditions of participation and any additional federal requirements for transplant facilities.

Transplantation related services and immunosuppressant drugs are not covered services for individuals in the Federal Emergency Services (FES) Program, pursuant to 42 U.S.C. 1396b(v)(3) and A.A.C. R9-22-206. Persons who qualify for transplant services, but who are later determined ineligible under A.R.S. 36-2907.10 due to excess income may qualify for extended eligibility (refer to AHCCCS Medical Policy 310-DD, Attachment A, Extended Eligibility Process/Procedure for Covered Solid Organ and Tissue Transplants).
**Assessment for Transplant Consideration**

The first step for transplant consideration is the initial assessment by the member’s Primary Care Provider (PCP) and/or the specialist treating the condition necessitating the transplant. In determining whether the member is appropriate for referral for transplant consideration, the PCP/specialist must determine that all of the following conditions are satisfied:

A. The member will be able to attain an increased quality of life and chance for long-term survival as a result of the transplant.

B. There are no significant impairments or conditions that would negatively impact the transplant surgery, supportive medical services, or inpatient and outpatient post-transplantation management of the member.

C. There are strong clinical indications that the member can survive the transplantation procedure and related medical therapy (e.g., chemotherapy, immunosuppressive therapy).

D. There is sufficient social support to ensure the member’s compliance with treatment recommendations such as, but not limited to, immunosuppressive therapy, other medication regimens and pre- and post-transplantation physician visits. For a pediatric/adolescent member, there is adequate evidence that the member and parent/guardian will adhere to the rigorous therapy, daily monitoring and re-evaluation schedule after transplant.

E. The member has been adequately screened for potential co-morbid conditions that may impact the success of the transplant. When the member’s medical condition is such that the evaluation must proceed immediately, the screenings may be provided by the PCP concurrent with the transplant evaluation.

F. The member’s condition has failed to improve with all other conventional medical/surgical therapies. The likelihood of survival with transplantation, considering the member’s diagnosis, age and comorbidities, is greater than the expected survival rate with conventional therapies. This information must be documented and submitted to the Division or the AdSS at the time of request for evaluation.

**AHCCCS Covered Solid Organ and Hematopoietic Stem Cell Transplants**

The Division covers solid organ and hematopoietic stem cell transplants covered services when medically necessary, cost effective, non-experimental, and not primarily for purposes of research. Live donor/kidney transplants are covered for pediatric and adult members.

Live donor transplants may be considered on a case-by-case basis for solid organs other than kidney when medically appropriate and cost effective. However, if a live donor transplant is approved for a non-kidney transplant, any costs related to the donor must not be separately reimbursed by AHCCCS or the Division, and no additional payment for the donor must be made unless the donor is AHCCCS eligible. Payment by AHCCCS and the Division for both the transplant recipient and the donor associated with non-kidney transplant services is limited to payment for the transplant and transplant-related services.
component during the 60-day post-transplant timeframe. Refer to the terms of the transplant contract for detailed information about coverage and payment for transplants and transplant-related services. For any additional charges, the living donor must accept the terms of financial responsibility for the charges associated with the transplant in excess of any payments under the transplant contract. Detailed criteria regarding specific transplants are found under the heading “Solid Organ and Related Devices: Specific Indications and Contraindications/ Limitations.”

The following transplants are covered subject to the terms of this policy:

<table>
<thead>
<tr>
<th>Transplant Type</th>
<th>Covered For ALTCS Members * (Under Age 21)</th>
<th>Covered For Adult Members Eligible For ALTCS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Solid Organs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Lung (single and double)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Heart/Lung</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Liver</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Kidney (cadaveric and live donor)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Simultaneous Liver/Kidney (SLK)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Simultaneous Pancreas/Kidney (SPK)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Pancreas After Kidney (PAK)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Pancreas Only</td>
<td>X</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Visceral Transplantation</td>
<td></td>
<td></td>
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<tr>
<td>Intestine alone</td>
<td></td>
<td></td>
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<tr>
<td>Intestine with pancreas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intestine with liver</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intestine, liver, pancreas en bloc</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partial pancreas (including islet cell transplants)</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Hematopoietic Stem Cell Transplants</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allogeneic Related</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Allogeneic Un-related</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Autologous</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Tandem Hematopoietic Stem Cell Transplant (HSCT)</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

*All other medically necessary, non-experimental transplants for members under the age of 21 are covered.

Other transplants and devices included in this policy are:

A. Circulatory Assist Device (CAD) is a covered service when used as a bridge to
transplantation and other specific criteria are met. Refer to “Solid Organ Transplants and Related Devices: Specific Indications and Contraindications/Limitations” within this policy section for more details.

B. Bone grafts and corneal transplants are covered services.

Coverage of transplantation services includes the following, as required by the specific type of transplant:

A. For the transplant candidate:

1. Donor search, human Leukocyte Antigens (HLA) typing, and harvest as necessary for stem cell transplants

2. Pre-transplant evaluation (inpatient or outpatient), which includes, but is not limited to:
   a. Physical examination
   b. Psychological and social service evaluations
   c. Laboratory studies
   d. X-ray and diagnostic imaging
   e. Biopsies

3. Pre-transplant dental evaluation and treatment of oral infection as described in Division Medical Policy 310-D, Exception for Transplant and Cancer Cases. Other dental services, including, but not limited to, restorative and cosmetic dentistry, will not be covered

4. Medically necessary post-transplant care (inpatient and outpatient), which may include, but is not limited to:
   a. Laboratory studies
   b. X-rays and diagnostic imaging
   c. Biopsies
   d. Home health
   e. Skilled Nursing Facility placement
   f. All related medications, including immunosuppressants

Note: The Division is the secondary payer of immunosuppressant medications if the member is also a Medicare beneficiary and is eligible to receive the immunosuppressant medications under Medicare Part B. Drugs covered under Medicare Part D are not covered for Division members eligible for Medicare whether or
not the member receives Medicare Part D coverage. Refer to Division Medical Policy 310-V, Prescription Medication/Pharmacy Services.

5. Transportation, room, and board for the transplant candidate and, if needed, one adult caregiver as identified by the transplant facility, to and from medical treatment during the time it is necessary for the member to remain in close proximity to the transplant center. This includes the evaluation, ongoing testing, transplantation, and post-transplant care by the transplant center.

B. For the donor:

Services are covered only when provided in the United States and are limited to the following:

a. Evaluation and testing for suitability
b. Kidney donor procurement or stem cell procurement, processing and storage.

c. Transportation, room and board to determine if the donor is a match or to donate either stem cells or organs under the transplant recipient’s benefit.

Refer to the contract for detailed information regarding coverage and payment for transplants and transplant-related services. Transplants and transplant related services are limited to coverage through day 60 post-transplant surgery for non-kidney transplants or, in the case of kidney transplants, through day ten post kidney transplant. Complications for the transplant recipient or donor arising from the transplant surgery during the 60/10 post-transplant timeframe are considered transplant related and covered under the scope of the follow up care component(s).

Payment for the 60/10 follow-up care component represents payment for services for both the recipient and the donor, and no additional reimbursement must be made except as specified below for complications extending beyond the 60/10 timeframe.

Complications extending beyond day 60/10 are covered for the recipient if the recipient is AHCCCS eligible and the services are medically necessary and covered. Complications for the donor beyond day 60/10 are covered only if the donor is AHCCCS eligible at the time the complication arises and the services are medically necessary and covered.

**Contraindications for All Transplants**

Contraindications to solid organ and hematopoietic stem cell transplantation include, but are not limited to:

A. History of non-compliance or psychiatric condition(s) such that there is an inability to comply with post-transplant protocol

B. HIV positive status and viral load – members whose HIV status makes them ineligible for coverage of transplantation have the potential to seek transplant in one
of the National Institute of Health’s approved sites. These transplants are subject to the section of this described in the section of this policy entitled “Medically Necessary Services for Members who receive Transplants that are Not Covered.”

C. For solid organ transplants, active malignancy or prior metastatic malignancy within the past five years, other than localized cutaneous basal cell or squamous cell cancers, is an absolute contraindication. The five-year time frame for malignancy does not apply to liver transplants for hepatocellular carcinoma. For stem cell transplants, active or prior metastatic solid tumors malignancy within the past five years, other than localized cutaneous basal cell or squamous cell cancer, is a contraindication.

D. The failure of more than two organs. This does not include instances where the failure of one organ is secondary to the failure of another organ.

E. Presence of active uncontrolled infection or systemic infection (sepsis) at the time of transplant is an absolute contraindication.

F. Active substance abuse or history of substance abuse in the last six months (if there is an urgent need, evaluation may be allowed on a case-by-case basis).

G. Lack of a psychosocial support system, which, based on the member’s condition and general health, would place the success of the transplant at risk.

H. Non-adherence with previous or current treatment protocols that has resulted in the failure of a previously transplanted organ is a contraindication to re-transplantation.

**General Medical Conditions That Must Be Considered**

The general medical conditions that must be evaluated prior to transplant to determine whether a particular transplant is medically necessary, cost effective, non-experimental, and not primarily for purposes of research include, but are not limited to:

A. When a transplant consultation is requested, the AdSS will approve a drug and alcohol screen to be done at the requesting transplant center for all members 21 years of age and older.

B. For members with a history of substance abuse within the past three years, the member must provide a certificate of completion of a 12-month substance abuse program which has been approved by the Administration prior to determination for the transplant evaluation. For members with a history of substance abuse **greater than three years from the date of the transplant consultation request**, attendance in an approved substance abuse program may be waived. Members with a history of substance abuse **within the past three-year timeframe** must have a total of three consecutive negative random screens prior to the evaluation. In addition, the member will be monitored with random and repeated alcohol and drug screenings during the assessment process up to the time of the transplant. At the time of transplant evaluation, members with a history of substance abuse **within the prior three-year timeframe** must sign an agreement which states they will enroll in a post-transplant substance abuse program that will continue for a
continuous 12-month timeframe.

C. It is within the AdSS’s discretion to require a psychosocial assessment be completed prior to referral for transplant evaluation.

D. Any history of post-transplant substance abuse will exclude a member from further transplant procedures.

Solid Organ Transplants and Related Devices: Specific Indications And Contraindications/Limitations

Heart Indications

Prior to listing heart transplant, all other medical and/or surgical alternatives for correction and/or management of the underlying heart conditions(s) must either have been optimized or ruled out as a viable treatment option(s).

Criteria for medical necessity of heart transplantation include, but are not limited to, the following indications:

A. Left ventricular systolic dysfunction of any etiology

B. Valvular disease with left systolic dysfunction, unable to be surgically corrected

C. Congenital cardiac disease that has failed prior correction

D. Sarcoidosis

E. Drug-induced myocardial destruction due to prescription medication

F. Ischemic cardiomyopathy with a New York Heart Association Class III or IV cardiac disease when surgical or medical therapy is not likely to be effective and estimated survival is less than six to 12 months without a transplant.

G. Hypertrophic cardiomyopathy

H. Uncontrollable life-threatening arrhythmias

I. Refractory angina unresponsive to maximal medical and/or surgical therapy.

Contraindications

In addition to the contraindications noted in “Contraindication for All Transplants” section of this policy, the following are contraindications to heart transplantation:

A. Severe Pulmonary hypertension - inability to achieve Pulmonary Vascular Resistance (PVR) of <2.5 Wood units and/or a 15 mm Hg transpulmonary gradient on maximal medical therapy including vasodilators or inotropic medications; these patients may instead be candidates for heart-lung transplantation

B. Acute severe hemodynamic compromise at the time of transplantation if accompanied by compromise or failure of one or more vital end-organs
C. Recent (within past six months) intracranial vascular disease or prior stroke with severe deficits
D. Severe peripheral vascular disease unable to be corrected surgically
E. Chronic obstructive pulmonary disease or chronic bronchitis
F. Recent and/or unresolved pulmonary infarction or pulmonary embolus
G. The need for or prior transplantation of another organ such as lung, liver, kidney or hematopoietic transplants
H. Autoimmune diseases or collagen vascular diseases are relative contraindications depending on the disease, severity, and predicted lifespan
I. Insulin-dependent diabetes mellitus with end-organ disease (e.g., peripheral vascular/arterial disease, retinopathy, neuropathy, or nephropathy)
J. Active peptic ulcer disease
K. Chronic inflammatory bowel disease
L. Hepatic insufficiency
M. Amyloidosis
N. Age over 70
O. HIV positive
P. Morbid obesity with Body Mass Index (BMI) of 35 kg/m².

**Circulatory Assistive Device (CAD) Formerly Known As Ventricular Assist Devices (VAD) And Total Artificial Hearts (TAH)**

The Division covers Circulatory Assist Devices (CADs) that support heart function as a bridge to heart transplant only, for eligible members when medically necessary, cost effective, non-experimental, not primarily for purposes of research, and when the device is used in accordance with the Food and Drug Administration (FDA) approved labeling instructions.

For purposes of this policy, Circulatory Assist Devices are defined as VADS and Total Artificial Hearts (TAH). TAH may be used in lieu of bi-VAD when clinically appropriate and cost effective.

AHCCCS-contracted transplant center surgeons use their skill and judgment to select the appropriate assist device, based on all of the following:

A. Degree and presentation of cardiac insufficiency
B. Size of recipient
C. Device capability.

**CAD Criteria**

Medical necessity for CADs as a bridge to transplant is based on the following criteria:

**Adult Member**

The potential *adult* recipient must meet all of the following:

A. Is actively listed for cardiac transplantation

   Note: If a member is on the inactive transplant list due to a temporary medical complication (e.g., Status 7) and undergoes placement of a VAD or Total Heart, separate payment for those devices is only made if the patient returns to active status and is medically able to undergo a transplant should an organ become available. Medical records must indicate resolution of the temporary medical condition and show Active status for transplant with UNOS. If the patient never returns to active status, the device is not paid for separately, but payment continues to be made for medical management of the patient, and

B. Is experiencing end stage heart failure with progressive failure to respond to medical management and meets the definition of cardiogenic shock according to the New York Heart Association (NYHA) functional classification system.

**Pediatric Member**

The potential *pediatric* recipient must meet all of the following:

A. Is actively listed for cardiac transplantation

   Note: If a member is on the inactive transplant list due to a temporary medical complication (e.g., Status 7) and undergoes placement of a VAD or Total Heart, separate payment for those devices is only made if the patient returns to active status and is medically able to undergo a transplant should an organ become available. Medical records must indicate resolution of the temporary medical condition and show active status for transplant with UNOS. If the patient never returns to active status, the device is not paid for separately, but payment continues to be made for medical management of the patient.

B. Age restrictions established by the FDA for the particular device used

C. Is in New York Heart Association class III or IV end-stage heart failure

D. Is refractory to medical therapy.
**Contraindications**

Contraindications to successful CAD placement and subsequent recovery include, but are not limited to:

A. Severe lung disease, except as appropriate for heart-lung transplantation (refer to the sections pertaining to lung and heart-lung transplantation in this policy)

B. Malignant disease

C. Stroke or refractory hypertension

D. Chronic pulmonary embolism or recent pulmonary infarction, except as appropriate for heart-lung transplantation (refer to the sections pertaining to lung and heart-lung transplantation in this policy)

E. Active infection

F. Irreversible disease of a major organ system, or

G. Critical psychosocial conditions, behaviors or problems in adherence to a disciplined medical regimen which preclude a positive transplant outcome.

**Lung Indications**

Criteria for medical necessity for lung transplantation include, but are not limited to, the following indications:

A. Alpha-1 antitrypsin deficiency

B. Primary pulmonary hypertension

C. Pulmonary fibrosis, idiopathic pulmonary fibrosis

D. Bilateral bronchiectasis

E. Cystic fibrosis (both lungs to be transplanted)

F. Bronchopulmonary dysplasia

G. Eisenmenger's syndrome

H. Sarcoidosis lung involvement

I. Scleroderma

J. Lymphangiomyomatosis

K. Eosinophilic granuloma

L. Pulmonary hypertension due to cardiac disease

M. Idiopathic fibrosing alveolitis.
Absolute Contraindications

In addition to the contraindications noted in “Contraindications for All Transplants” section of this policy, absolute contraindications to lung transplantation, include, but are not limited to:

A. Primary or metastatic malignancies of the lung
B. Colonization with highly resistant or highly virulent microorganisms
C. Untreatable, advanced dysfunction of any other organ (except the heart when a heart/lung transplant may be indicated
D. Non-curable extra-pulmonary chronic infection
E. Inadequate biventricular cardiac function, significant coronary artery disease, or inadequate left ventricular function (these are not absolute contraindications if combined with a heart transplant)
F. System-wide involvement of cystic fibrosis
G. End Stage Renal Disease (ESRD)
H. Active tuberculosis.

Relative Contraindications

In addition to the absolute contraindications noted above, relative contraindications to lung transplantation, include, but are not limited to:

A. Acute respiratory insufficiency or failure requiring mechanical ventilation except adults with cystic fibrosis, where mechanical ventilation has not been shown to affect transplant survival
B. Abscess of lung and mediastinum
C. Significant chest wall and/or spinal deformity; prior thoracic surgery or other basis for pleural adhesions
D. Current significant acute illness that is likely to contribute to a poor outcome if the member receives a lung transplant
E. Chronic, incurable pulmonary infection in candidates for single lung transplantation
F. Continued cigarette smoking or failure to have abstained for a period of 12 months or longer.
G. Chronic cortisone therapy with more than 20 mg prednisone daily or recent therapeutic use of systemic steroids.
H. Severely limited functional status with low potential for rehabilitation
I. HIV positive
J. Active infection with Hepatitis B or C with a detectable viral load
K. Diabetes with end-organ dysfunction (e.g., peripheral vascular/arterial disease, retinopathy, neuropathy, or nephropathy)
L. Osteoporosis with vertebral collapse compression fractures
M. Age over 65
N. Hepatic insufficiency
O. Morbid obesity with 30 kg/m².

**Heart and Lung Indications**

Criteria for medical necessity for heart/lung transplantation include, but are not limited to, the following indications:

A. Irreversible primary pulmonary hypertension with congestive heart failure
B. Non-specific pulmonary fibrosis
C. Eisenmenger’s complex with irreversible pulmonary hypertension and heart failure
D. Cystic fibrosis with severe heart failure
E. Emphysema with severe heart failure
F. Chronic Obstructive Pulmonary Disease (COPD) with severe heart failure.

**Contraindications**

Refer to the individual heart and lung sections in this policy for contraindications.

**Liver**

Timing of referral:

Prior to referral to a transplant center for evaluation, the AdSS must calculate the adult member’s Model for End stage Liver Disease (MELD) score. An adult member must have a MELD score greater than 10 to meet criteria for referral.

The AdSS must calculate the pediatric member’s Pediatric End stage Liver Disease (PELD) score prior to transplant evaluation. The PELD score automatically assigns additional points for a child.

**Indications for Adult and Pediatric Liver Transplants**

Criteria for medical necessity for liver transplantation in adults and pediatric liver transplants (except as otherwise indicated) include, but are not limited to, the following indications:
A. Fulminant hepatic failure – This is an emergent basis for transplant (viral [A, B and Non-A-Non-B], toxins, drugs, Wilson’s Disease, idiopathic)
B. Primary/secondary biliary cirrhosis
C. Primary sclerosing cholangitis
D. Cryptogenic or autoimmune cirrhosis
E. Chronic active hepatitis due to Hepatitis B, C or delta hepatitis
F. Alcoholic liver disease after a period of abstinence of six months or more
G. Alpha-1 antitrypsin deficiency (non-acquired)
H. Wilson’s Disease
I. Primary hemochromatosis
J. Protoporphyria
K. Familial Intrahepatic Cholestasis (Byler’s disease)
L. Trauma
M. Drug-or toxin-induced liver disease (including but not limited to iatrogenic origin)
N. Extrahepatic biliary atresia, intrahepatic bile duct paucity (Alagille syndrome), and obstructive biliary disease
O. Budd-Chiari syndrome
P. Biliary dysplasia
Q. Metabolic liver disorders
R. Cholangiocarcinoma (for adults: when a transplant center applies for a MELD exception for unresectable cholangiocarcinoma based on underlying liver disease or due to technical considerations, mass < 3 cm. and with intrahepatic and extrahepatic metastases excluded)
S. Hepatocellular Carcinoma (HCC) when all of the following conditions are met:
   1. The member is not a candidate for subtotal liver resection
   2. The member has a single tumor less than or equal to 5 cm in diameter or up to 3 lesions each smaller than 3 cm
   3. There is no macrovascular involvement or identifiable extrahepatic spread of tumor to surrounding lymph nodes, lungs, abdominal organs or bones, and
   4. This is not a recurrence of previous resected or treated HCC.
T. Re-transplantation when any of the following occurs:

1. Chronic rejection with documented adherence to the post-transplant protocols
2. Biliary stricture
3. Hepatic artery thrombosis
4. Graft thrombosis
5. Sickle cell hepatopathy
6. Hepatic veno-occlusive disease
7. Reinfection with the Hepatitis C virus following a liver transplant is an absolute contraindication to re-transplantation.

**Additional Indications Limited to Pediatric Transplants**

Criteria for medical necessity for liver transplantation limited to the pediatric population include, but are not limited to, the following indications:

A. Intractable cholestasis, intrahepatic (idiopathic neonatal hepatitis)
B. Portal hypertension
C. Multiple episodes of ascending cholangitis
D. Failure of synthetic function
E. Failure to thrive, malnutrition
F. Intractable ascites
G. Encephalopathy
H. Caroli’s with Congestive Heart Failure (CHF)
I. Cystic fibrosis
J. Metabolic defects for which liver transplantation will reverse life threatening illness and prevent irreversible Central Nervous System (CNS) damage; the following may be underlying diagnoses/disorders that lead to pediatric liver transplantation:

1. Urea cycle defects
2. Selected organic acidemias
3. Crigler-Najjar Syndrome
4. Familial hypercholesterolemia
5. Neonatal iron storage disease  
6. Hyperoxaluria Type I  
7. Hemophilia A and B  
8. Tyrosinemia  
9. Glycogen storage disease (I, III, IV)  
10. Glycogen debrancher deficiency 1B  
11. Disorders of bile acid metabolism  
12. Lipid storage disease, and  
13. Protein C Deficiency  

K. Malignancy including but not limited to:  
   1. Hepatoblastoma  
   2. Hepatocellular carcinoma  
   3. Hemangioendothelioma  
   4. Sarcomas, and  
   5. Neuroendocrine tumors when the tumor does not extend beyond the margins of the liver.

**Contraindications Limited to Adults**  
In addition to the contraindications noted in the “Contraindications for All Transplants” section of this policy, contraindications to liver transplantation in *adults*, include, but are not limited to:  

A. Malignancies, other than Hepatocellular Carcinoma (HCC) with the criteria previously stated in this section  

B. Acute severe hemodynamic compromise at the time of transplant if accompanied by compromise or failure of one or more vital organs  

C. The need for prior transplantation of another organ such as lung, kidney, heart or blood or marrow if this represents a co-existence of significant disease  

D. Insulin-dependent diabetes mellitus with end-organ disease  

E. Gross vascular invasion of hepatocellular carcinoma  

F. Systemic diseases that will result in member death regardless of liver transplant  

G. Morbid obesity with BMI >35 kg/m².
Contraindications Limited to Pediatric Liver Transplants

In addition to the contraindications noted in the “Contraindications for All Transplants” section of this policy, contraindications to liver transplantation in the pediatric population include, but are not limited to:

A. Persistent viremia
B. Active sepsis
C. Severe cardio-pulmonary comorbidities
D. Severe neurological disorder
E. Gross vascular invasion of hepatocellular carcinoma
F. Malignancy extending beyond the margins of the liver with exception of neuro-endocrine tumors metastatic into the liver
G. Systemic diseases that will result in member death despite liver transplant.

Kidney Indications

Criteria for medical necessity for live donor or cadaveric kidney transplantation includes, but is not limited to, and or all of the following indications:

A. All dialysis or advanced chronic kidney disease patients are transplant candidates until deemed unsuitable for transplant. Transplant is usually indicated when Glomerular Filtration Rate (GFR) falls below 20 ml/min,
B. When the onset of dialysis is expected in the next six months (pre-emptive transplant).
C. Symptomatic uremia at GFR above 20 ml/min.

Indications Limited to the Pediatric Population

For pediatric kidney transplants, additional criteria for transplantation include, but are not limited to:

A. Wilm’s tumor (non-metastatic)
B. Oxalosis (may also require a liver-kidney transplant and will be considered on a case-by-case basis)

Contraindications

In addition to the contraindications noted in the “Contraindications for All Transplants” section of this policy, contraindications to kidney transplantation include, but are not limited to any of the following:

A. Potential complications from immunosuppressive regimens that are unacceptable to
the member (the benefits of remaining on dialysis outweigh the risks of transplantation)

B. Structural problems, or abnormalities with the lower urinary tract, which interfere with normal renal function of the transplanted kidney

C. Severe cardiomyopathy or ischemic heart disease that is not correctable

D. Cardiac ejection fraction <30%

E. Hepatic cirrhosis

F. Diffuse, pronounced vascular disease that is not correctable

G. Active peptic ulcer disease

H. Any chronic medical condition besides chronic kidney dysfunction where life expectancy is less than two years

I. Morbid Obesity with BMI > 35 kg/m².

Living Kidney Donor Exclusion Criteria

A. To qualify as a living kidney donor, the donor must be at least 18 but not more than 65 years of age and must be able to give informed consent.

B. In addition, the donor will not be considered if he/she has any of the following:

   1. Hypertension (>140/90 or requires medication)
   2. Diabetes or abnormal glucose intolerance test
   3. Proteinuria >250 mg/24 hours
   4. Recent or recurrent kidney stones
   5. Donors with a history of familial kidney disease such as Alport Syndrome, polycystic kidney disease, and nephrotic syndrome must be assessed for risk
   6. Abnormal glomerular filtration rate, creatinine clearance <80 mL/min
   7. Microscopic hematuria
   8. Structural abnormalities in donor kidney
   9. History of prior malignancy other than cutaneous squamous or basal cell cancer
   10. Significant co-morbid medical conditions (e.g., malignancy, COPD)
   11. Obesity (with BMI >35 kg/m²)
   12. History of thrombosis or thromboembolism
13. Psychiatric contraindications including active substance abuse.

**Simultaneous Liver/Kidney (SLK)**

Timing of referral:

A. Prior to referral to a transplant center for evaluation, the AdSS must calculate the adult member’s Model for End stage Liver Disease (MELD) score. An adult member must have a MELD score greater than 10 to meet criteria for referral.

B. The Contractor must calculate the pediatric member’s Pediatric End stage Liver Disease (PELD) score prior to transplant evaluation. The PELD score automatically assigns additional points for a child.

**Indications for Simultaneous Liver/Kidney Transplants**

Refer to the individual liver and kidney sections in this policy for indications and general medical considerations.

**Contraindications for Simultaneous Liver/Kidney Transplants**

Refer to the individual liver and kidney sections in this policy for contraindications and general medical considerations.

**Simultaneous Pancreas/Kidney (SPK)**

Indications for Simultaneous Pancreas/Kidney (SPK) Transplantation

Criteria for medical necessity for simultaneous pancreas/kidney transplantation include, but are not limited to, the following indications:

A. Insulin-dependent diabetes mellitus with impending renal failure, and

B. The member is an acceptable candidate for pancreas transplantation

**Contraindications**

In addition to the general contraindications noted in the "Contraindications for All Transplants" section of this policy, contraindications to SPK include, but are not limited to, any of the following:

A. Uncorrectable cardiovascular or peripheral vascular disease

B. Cardiac ejection fraction < 30%

C. Peripheral vascular disease that is not correctable

D. Active substance abuse

E. End-organ disease, in other than pancreas or kidney, secondary to insulin-dependent diabetes mellitus
F. Morbid obesity with BMI >30 kg/m².

**Pancreas After Kidney (PAK)**

For members under age 21 eligible for the ALTCS Program, covered services are limited to total pancreas only after kidney transplant. Partial pancreas and islet cell transplantation are not covered for both members under 21 and member's age 21 years and older.

**Indications for Pancreas After Kidney Transplantation**

Criteria for medical necessity of pancreas after kidney transplantation include, but are not limited to:

A. Achievement of adequate renal function post kidney transplantation

B. Extreme labile Type I diabetes that has not responded to conventional therapy including an insulin pump.

**Contraindications**

In addition to the general contraindications noted in the “Contraindications for All Transplants” section of this policy, contraindications to pancreas after kidney transplantation include, but are not limited to:

A. Uncorrectable cardiovascular or peripheral vascular disease

B. Cardiac ejection fraction < 30%

C. Peripheral vascular disease that is not correctable

D. Active substance abuse

E. End-organ disease, in other than pancreas or kidney, secondary to insulin-dependent diabetes mellitus

F. Morbid obesity with BMI >30 kg/m².

**Pancreas Only**

Pancreas-only transplants are limited to members under age 21 eligible for the ALTCS Programs when the member meets the criteria below.

A. Documented pancreas organ failure

B. Documented medically uncontrollable labile insulin-dependent diabetes mellitus with documented recurrent, severe, acutely life-threatening metabolic complications that require frequent (three or more emergency room visits or hospital admissions in a three-month period) hospitalization

C. Hospitalizations related to complications due to frequent hypoglycemia unawareness or recurring severe ketoacidosis, or recurring hypoglycemic attacks, and
D. Management by an endocrinologist for a minimum of 12 months with the most medically recognized advanced insulin formulations and delivery systems, including insulin pump therapy if appropriate.

Note: For individuals age 21 and older, AHCCCS covers pancreas after kidney and simultaneous pancreas/kidney transplants. Pancreas-only transplants are not a covered benefit for adults unless the member has previously had a Pancreas After Kidney transplant or Simultaneous Pancreas/Kidney transplant and the pancreas is failing.

Visceral Transplants

A. Visceral transplantation is limited to members who are under 21 years of age and meet the medical eligibility criteria.

B. Cadaveric en bloc visceral transplants involving pancreas/liver/small bowel are covered when clinically indicated.

Indications For Members Under Age 21 Eligible For The ALTCS Program

Criteria for visceral transplantation alone, and combined small bowel/liver/pancreas transplantation in any combination include, but are not limited to the following conditions:

A. Small bowel syndrome resulting from inadequate intestinal propulsion due to neuromuscular impairment

B. Small bowel syndrome resulting from post-surgical conditions due to resections for any of the following:
   1. Intestinal cysts
   2. Mesenteric cysts
   3. Tumors involving small bowel
   4. Crohn’s disease
   5. Mesenteric thrombosis
   6. Volvulus.

C. Short-gut syndromes in which there is liver function impairment (usually secondary to Total Parenteral Nutrition [TPN])

D. Impending or overt liver or pancreas failure due to TPN-induced liver injury, with clinical manifestations including elevated serum bilirubin and/or liver enzymes, splenomegaly, thrombocytopenia, gastroesophageal varices, coagulopathy, stomal bleeding or hepatic fibrosis/cirrhosis

E. Thrombosis of two or more major central venous channels (jugular, subclavian or femoral veins)
F. Two or more episodes per year of systemic sepsis secondary to line infection, which require hospitalization, indicating failure of TPN therapy

G. Frequent episodes of severe dehydration despite intravenous fluid supplement in addition to TPN

H. Gastrochisis.

**Contraindications for Members Under Age 21 Eligible for the ALTCS Program**

In addition to the general contraindications noted in the “Contraindications for All Transplants” section of this policy, contraindications to visceral transplantation include, but are not limited to, the following conditions:

A. Insufficient vascular patency

B. Life-threatening and non-correctable illness not related to the digestive system such as:
   1. Profound neurological disability
   2. Chronic cardio-pulmonary disease.

**Hematopoietic Stem Cell Transplants (HSCT)**

Hematopoietic Stem Cell Transplant (HSCT) is the transplantation of blood stem cells derived from the bone marrow or blood, including cord blood. Conditioning therapy includes either myeloablative or non-myeloablative induction with or without Total Body Irradiation (TBI).

Medical necessity for Cord Blood Transplantation (CBT) in adults will be determined on a case-by-case basis. For any pediatric CBT, a single cord blood unit will be considered standard treatment.

**Autologous HSCT**

Criteria for medical necessity for autologous HSCT include, but are not limited to, any of the following indications:

A. Adults
   1. Acute Myelogenous Leukemia (AML) in remission
   2. Chronic Myelogenous Leukemia (CML) in remission
   3. Relapsed Hodgkin Lymphoma that is chemosensitive
   4. Mantle cell lymphoma that is chemosensitive
   5. Germ cell tumors (tandem)
   6. Multiple myeloma (tandem)
7. Amyloidosis in patients with adequate organ function
8. Waldenstrom’s macroglobulinemia
9. Non-Hodgkin lymphoma subtypes where peer-reviewed data has confirmed safety and efficacy of the proposed transplant procedure.

B. Pediatric
1. Neuroblastoma (tandem appropriate if done per a clinical trial)
2. Medulloblastoma
3. Brain tumors, other than medulloblastoma, including central nervous system germ cell tumors, Peripheral Neuro-Ectodermal Tumor (PNET), atypical Teratoid/Rhabdoid Tumor (AT/RT), oligodendroglioma, and pineoblastoma, where peer-reviewed data on safety and efficacy for the proposed transplant procedure have been successfully demonstrated. Relapsed chemo-sensitive Hodgkin lymphoma
4. Relapsed chemo-sensitive Non-Hodgkin lymphoma
5. Other pediatric solid tumors (Wilm’s tumor, Ewings sarcoma, etc.) where peer-reviewed data on safety and efficacy for the proposed transplant have been successfully demonstrated.

Whether a specific disease meets the criteria for autologous HSCT is determined by current guidelines as published by specialty societies such as the American Society for Blood and Marrow Transplantation (ASBMT) and the Children’s Oncology Group (COG).

Contraindications

In addition to the general contraindications noted in the "Contraindications for All Transplants" section of this policy, contraindications to Autologous HSCT include, but are not limited to, the any of the following conditions:

A. Evidence of cirrhosis or significant liver dysfunction, since this can be a factor for development of Sinusoidal Obstruction Syndrome (SOS) formerly called Veno-Occlusive Disease (VOD)

B. Uncontrolled, progressive or active systemic infection at the time of transplant is an absolute contraindication. Prior infection, or infection where there is relative control with a post-transplant plan of control, is not an absolute contraindication and must be considered on a case-by-case basis

C. Prior malignancy, other than disease being treated by transplant, within the last five years. These must be considered on a case-by-case basis

D. Cystic fibrosis (absolute) and other multi-system disease not correctable by hematopoietic stem cell transplantation
E. End-organ damage of either heart or lungs

F. Parenchymal brain disease that raises the risk of cerebrovascular hemorrhage

G. Prior allogeneic hematopoietic stem cell transplant is a relative contraindication depending on disease responsiveness, disease control, patient’s performance status, and presence of other co-morbidities. These must be considered on a case-by-case basis.

**Allogeneic HSCT**

Criteria for medical necessity for Allogeneic HSCT include, but are not limited to, the following indications:

A. Adults

1. Acute Myelogenous Leukemia
   
   a. Primary indication failure or slow to induce or refractory disease
   
   b. In first complete remission, if patient at moderate risk for relapse per standard criteria and a match, related donor is available
   
   c. In first complete remission, if patient at high-risk for relapse per standard criteria and has either a match, related donor or a well-matched unrelated donor available
   
   d. In second complete remission

2. Acute Lymphogenous Leukemia, in remission

3. Chronic Myelogenous Leukemia
   
   a. Unresponsive to tyrosine kinase inhibitor control with three prior lines of therapy
   
   b. Intolerance to tyrosine kinase inhibitors or has severe side effects
   
   c. Accelerated phase or blast crisis

4. Relapsed or progressive Hodgkin lymphoma that is chemosensitive

5. Relapsed or progressive large cell Non-Hodgkin lymphoma that is chemosensitive

6. Chemosensitive low-grade or follicular Non-Hodgkin lymphoma when clinical evidence indicates transformation to more aggressive subtype (Richter transformation)

7. Relapsed or progressive Non-Hodgkin lymphoma that is chemosensitive and there is peer-reviewed data demonstrating both safety and efficacy for the particular NHL subtype involved
8. Myelodysplastic Syndrome with acceptable donor (either a matched, related donor or well, matched, unrelated donor)

9. Fanconi Anemia

10. Other Hematological Disorders for which peer-reviewed data on safety and efficacy for proposed transplant have been successfully demonstrated including, but not limited to:
   a. Sickle cell disease
   b. Severe congenital anemia
   c. Thalassemia.

B. Pediatric

1. Acute Myelogenous Leukemia

2. Juvenile Myelomonocytic Leukemia, at any stage, with any donor type

3. Chronic Myelogenous Leukemia
   a. Unresponsive to tyrosine kinase inhibitor control (usually three prior lines of therapy
   b. Intolerance to tyrosine Kinase inhibitors,
   c. Accelerated phase or blast crisis

4. Acute Lymphogenous Leukemia
   a. In first complete remission, if high-risk for relapse; or primary indication failures who subsequently achieve a first complete remission
   b. T-cell Acute Lymphogenous Leukemia in first complete remission with early marrow relapse (<six months)
   c. In the second complete remission, if early relapse (less than 36 months remission)

5. Relapsed or progressive Hodgkin Lymphoma that is chemosensitive

6. Relapsed or progressive Non-Hodgkin Lymphoma that is chemosensitive, and there is peer-reviewed data demonstrating safety and efficiency of the proposed procedure for the particular Non-Hodgkin Lymphoma subtype involved

7. Inborn errors of Metabolism in patients who have not yet suffered either significant or irreversible end-organ damage

Example Indications:
8. Primary lethal immune deficiencies and hemophagocytic lymphohistiocytosis such as:
   a. Wiskott-Aldrich Syndrome,
   b. Severe combined immune deficiencies (SCID), and

9. Fanconi Anemia

10. Other Hematological Disorders for which peer-reviewed data on safety and efficacy for the proposed transplant have been successfully demonstrated, including but not limited to:
   a. Sickle cell disease,
   b. Severe congenital anemia
   c. Thalassemia.

**Contraindications**

In addition to the contraindications noted in the “Contraindications for All Transplants” section of this policy, contraindications to allogeneic HSCT include, but are not limited to, the following conditions:

A. Evidence of cirrhosis or sever liver dysfunction
B. Cystic fibrosis is an absolute contraindication
C. Uncontrolled, progressive or active systemic infection at the time of transplant is an absolute contraindication
D. End-organ damage of either heart or lungs
E. Parenchymal brain disease that poses a risk for cerebrovascular hemorrhage
F. Prior hematopoietic stem cell transplant is a relative contraindication depending on
disease responsiveness, disease control, patient’s performance status, and presence of other co-morbidities. These must be considered on a case-by-case basis.

**Out-Of-Network Coverage**

The AdSSs must provide out-of-network coverage for solid organ or hematopoietic stem cell transplants for those members who have current medical requirements that cannot be met by an appropriate in-network transplant center. These medical requirements must be manifested as requiring either a specific level of technical expertise or program coverage that is not currently provided by an AHCCCS contracted facilities. A request for out-of-network coverage will not be approved if the member has already received a medical denial from an AHCCCS contracted transplant center. The use of out-of-network transplant centers is determined by the review of quality and outcome data, as published by center’s accreditation organization, and the center’s cost containment standards.

When a member completes a Division approved transplantation at an out-of-network facility, the necessary follow-up services will be covered through an AHCCCS contracted in-network facility, if one is available. These services include, but are not limited to, travel, lodging, meals, medical testing and post-operative evaluation and apply to any transplant performed under AHCCCS coverage, another third-party payer or through self-pay.

**Multiple Site Listing For Solid Organ/Hematopoietic Transplantation**

If a member seeks to be evaluated for solid organ, or hematopoietic stem cell transplantation and is "listed" with more than the primary AHCCCS contracted transplant center, the Division will only pay for one center’s evaluation services.

If a member becomes listed by a facility other than the primary AHCCCS contracted transplant center, the Division will not provide coverage for any costs in excess of the state-contracted rate for the specific transplant procedure.

In addition, reimbursement will be available only to FACT accredited or UNOS approved facilities. Facilities must be CMS certified transplant centers and must meet the Medicare conditions of participation and the special requirements for transplant centers set forth in 42 CFR Part 482.

If a member chooses to make his/her own arrangements for travel, lodging and/or meals, the member must notify the AdSS of the arrangements they have made. In addition, the member, in such circumstances, is responsible for securing and sending appropriate medical records to the appropriate transplant case manager.

**Non-transplant Medically Necessary Services Covered by AHCCCS for Members Who Receive Non-covered Transplants**

If a member receives a transplant that is not covered by the Division, medically necessary, non-experimental services commence following discharge from the acute care hospitalization for the transplant.

A. Covered services include, but are not limited to:
   a. Transitional living arrangements appropriately ordered for post-transplant
members when the member does not live in close proximity to the center

b. Essential laboratory and radiology procedures
c. Medically necessary post-transplant therapies
d. Immunosuppressant medications
e. Medically necessary transportation.

B. Covered services do not include:

a. Evaluations and treatments to prepare for transplant candidacy
b. The actual transplant procedure and accompanying hospitalization
c. Organ or tissue procurement.

Division reimbursement of the AdSS for medically necessary services following non-covered organ transplantation is in accordance with the regular reinsurance guidelines found in the AHCCCS Reinsurance Processing Manual as adopted by the Division. Division-covered transplantation and its related medically necessary services are reimbursed in accordance with the transplant reinsurance guidelines found in the Reinsurance Processing Manual, with the exception of kidney transplants, cornea transplants and bone grafts. These services are covered as part of regular capitation payments and any related services may be covered in accordance with the regular reinsurance guidelines.

**Transplantation Management**

The AHCCCS Administration has entered into a contract with a transplantation management entity (consultant) to review developments, outcomes and respective changes in technology, and assist in the development and revision of this policy. The consultant will be available, as necessary, to provide expertise regarding clinical issues arising from transplant requests.

Although the AdSS is encouraged to consult with the transplantation management entity (AHCCCS consultant) under contract with AHCCCS for guidance in making medical determinations regarding transplants. The AdSS is not required to use the AHCCCS consultant in reaching its medical determination. The AdSS may obtain its own expert opinion. A written medical justification for the AdSS’s decision is required in each case.

AHCCCS, in partnership with the consultant, is available to assist with questions and issues concerning specific diagnoses and medical conditions that are covered for transplantation.

Consultation may include, but is not limited to:

A. Telephone access to the Consultant Medical Director. Access will be arranged by the DHCM Medical Management Unit

B. Regular updates on changes in experimental status of selected transplants and advances in technology and devices
C. Analysis of transplantation and related technology developments with enough information, including cost projections, to assist AHCCCS in revising this policy as necessary.

D. Assistance in recommendation of approved/appropriate transplant facilities, as necessary, for out-of-network coverage.
310-FF  MONITORING CONTROLLED AND NON-CONTROLLED MEDICATION UTILIZATION

EFFECTIVE DATE: October 1, 2019
REFERENCES: Section F3, Contractor Chart of Deliverables
DELIVERABLES: Pharmacy and/or Prescriber - Member Assignment/Restrictions Report

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The AdSS must engage in activities to monitor controlled and non-controlled medication use. The policy also sets forth minimum requirements to ensure members receive clinically appropriate prescriptions. These requirements are also referred to as interventions.

Definitions

A. Controlled Substance - Drugs and other substances that are defined as controlled substances under the Controlled Substance Act (CSA).

B. CSPMP - Arizona State Board of Pharmacy Controlled Substance Prescription Monitoring Program.

C. Drug Diversion - Redirection of prescription drugs for illicit purposes.

D. Exclusive Pharmacy - Individual pharmacy, which is chosen by the member or assigned by the AdSS to provide all medically necessary federally reimbursable pharmaceuticals to the member.

Minimum Monitoring Requirements

A. The AdSS is required to monitor controlled and non-controlled medications on an ongoing basis. Monitoring must include, at a minimum, the evaluation of prescription use by members, prescribing patterns by clinicians and dispensing by pharmacies. Drug use data must be used to identify and screen high-risk members and providers who may facilitate drug diversion. The monitoring requirements are to determine potential misuse of the drugs used in the following therapeutic classes:

1. Atypical Antipsychotics,
2. Benzodiazepines,
3. Hypnotics,
4. Muscle Relaxants,
5. Opioids, and

B. The AdSS must use the following resources, when available, for their monitoring activities:

1. Prescription claims data,
2. CSPMP,
3. Indian Health Service (IHS) and Tribal 638 pharmacy data, and
4. Other pertinent data.

C. The AdSS must evaluate the prescription claims data, at a minimum, quarterly, to identify:
   1. Medications filled prior to the calculated days-supply,
   2. Number of prescribing clinicians,
   3. Number of different pharmacies used by the member, and
   4. Other potential indicators of medication misuse.

**Minimum Intervention Requirements**

The AdSS must implement the following interventions to ensure members receive the appropriate medication, dosage, quantity, and frequency:

A. Provider education in accordance to AMPM Policy 310-V.
B. Point-of-Sale (POS) safety edits and quantity limits.
C. Care/case management.
D. Referral to, or coordination of care with, a behavioral health service provider(s) or other appropriate specialist.
E. Assignment of members who meet any of the evaluation parameters in Table 1 to an exclusive pharmacy, in accordance with 42 CFR 431.54, for a minimum 12-month period except for the following members. The AdSS may assign members who meet these parameters to a single prescriber in addition to the assignment to an exclusive pharmacy. Members with one or more of the following conditions must not be subject to the intervention requirements described in subsections A through D:
   a. Treatment for an active oncology diagnosis,
   b. Receiving hospice care, or
   c. Residing in a skilled nursing facility or intermediate care facility.
Table 1 Program Evaluation Criteria

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<th>EVALUATION PARAMETER</th>
<th>MINIMUM CRITERIA FOR INITIATING INTERVENTIONS</th>
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| OVERUTILIZATION      | Member used the following in a three-month time period:  
                       > Four prescribers; and  
                       > Four different abuse potential drugs; and  
                       > Four Pharmacies.  
                       OR  
                       Member has received 12 or more prescriptions of the medications listed in Minimum Monitoring Requirements in the past 3 months. |
| FRAUD                | Member has presented a forged or altered prescription to the pharmacy. |

F. A member who is assigned to an exclusive pharmacy and/or an exclusive prescriber for 12 months must be provided a written notice detailing the factual and legal based for the restriction. This restriction must be treated as an “action” pursuant to A.A.C. R9-43-202 and A.A.C. R9-34-302. The written notice must inform the member of the opportunity to file an appeal and the timeframes and process for doing so as described in A.A.C. Title 9, Chapter 34, Articles 2 and 3. Neither the Division nor the AdSS shall implement the restriction before providing the member notice and opportunity for a hearing. If the member has filed an appeal, no restriction shall be imposed until:

1. Director’s Decision has affirmed the restriction,
2. The member has voluntarily withdrawn the appeal or request for hearing, or
3. The member fails to file an appeal or request for hearing in a timely manner.

G. At the end of the designated time period, the AdSS must review the member’s prescription and other utilization data to determine whether the intervention will be continued or discontinued. The AdSS must notify the member in writing of the decision to continue or discontinue the assignment of the pharmacy and/or provider. If the decision is to continue the assignment, the AdSS is required to include instructions for the appeals/fair hearing process in the notification letter to the member.

H. The intervention of assigning an exclusive pharmacy and/or provider does not apply to emergency services furnished to the member. The AdSS must ensure that the member has reasonable access to services covered by the Division of Developmental
Disabilities (Division), taking into account the geographic location and reasonable travel time. The AdSS must provide specific instructions to the member, the assigned exclusive pharmacy and/or exclusive provider, and their Pharmacy Benefit Manager (PBM), on how to address the following:

1. Emergencies defined as medical services provided for the treatment of an emergency medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:
   a. Placing the member’s health in serious jeopardy,
   b. Serious impairment to bodily functions, or
   c. Serious dysfunction of any bodily organ or part,

2. The medication is out-of-stock at the exclusive pharmacy, or

3. The exclusive pharmacy is closed.

**Reporting Requirements**

A. Identified cases of member deaths due to medication poisoning/overdose or toxic substances must be referred to the Division’s Quality Management staff for research and review.

B. The AdSS must report all suspected fraud, waste, and abuse, to the appropriate entity, and copy the Division as specified in Section F3, Contractor Chart of Deliverables.

C. The AdSS must report to the Division, as specified in the Section F3, Contractor Chart of Deliverables, the number of members on that day that are assigned to an exclusive pharmacy and/or single prescriber, due to excessive use of prescriptive medications (narcotics and non-narcotics).

D. The AdSS are also required to report to the Division as specified in the Section F3, Contractor Chart of Deliverables, when the AdSS have additional changes and implements additional interventions and more restrictive parameters as noted in this policy.

E. The Division will work with all appropriate entities regarding the implementation of the interventions outlines above on an as-needed basis.
310-GG NUTRITIONAL THERAPY, METABOLIC FOODS, AND TOTAL PARENTAL NUTRITION

EFFECTIVE DATE: October 1, 2019
REFERENCES: AMPM, Chapter 310-GG, Attachment A - AHCCCS Certificate of Medical Necessity for Commercial oral Nutritional Supplements, for Members 21 Years of Age and Older – Initial or Ongoing Requests

Purpose

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). This Policy establishes requirements regarding nutritional assessments, nutritional therapy, including metabolic foods, commercial oral supplements, and total parental nutrition for members 21 years of age and older.

Definitions:

A. Commercial Oral Supplemental Nutrition - Nourishment available without a prescription that serves as sole caloric intake or additional caloric intake to.

B. Enteral Nutrition - Liquid nourishment provided directly to the digestive tract of a member who cannot ingest an appropriate number of calories to maintain an acceptable nutritional status. Enteral nutrition is commonly provided by J-tube, G-tube or N/G tube.

C. Metabolic Medical Food Formulas or Medical Foods - Nutrition and specialized diets used to treat inherited metabolic disorders that are rare genetic conditions in which normal metabolic function is inhibited by a deficiency in a critical enzyme. Metabolic formula or modified low protein foods are produced or manufactured specifically for persons with a qualifying metabolic disorder and are not generally used by persons in the absence of a qualifying metabolic disorder. In order to avoid toxic effects, the treatment of the associated metabolic disorder depends on dietary restriction of foods containing the substances that cannot be metabolized by the member.

D. Total Paternal Nutritional (TPN) Therapy - Nourishment provided through the venous system to members with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength appropriate for the individual’s general condition. Nutrients are provided through an indwelling catheter.

Policy

A nutritional assessment is required for a member who has been identified as having a health status which may improve or be maintained with nutrition intervention such as nutritional therapy.

Refer to AdSS Medical Policy 430 for requirements specific to nutritional assessments and nutritional therapy for all members 20 years of age and under.

AHCCCS covers the nutritional assessment as determined medically necessary and as a part of health risk assessment and screening services provided by the member’s Primary Care Provider (PCP). Nutritional assessment services provided by a registered dietitian also are
covered when ordered by the member’s PCP.

AHCCCS covers nutritional therapy on an enteral, parenteral or oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member’s daily nutritional and caloric intake. AdSS follows Medicare requirements for the provision of TPN services.

**Prior Authorization**

Prior Authorization (PA) from the AdSS is required for commercial oral nutritional supplements, enteral nutrition, and parenteral nutrition unless:

A. The member is currently receiving nutrition through enteral or parenteral feedings for which PA has already been obtained.

B. For the first 30 days with members who require oral supplemental nutritional feedings on a temporary basis due to an emergent condition; i.e. post-hospitalization.

**Commercial Oral Nutritional Supplements**

Medical necessity for commercial oral nutritional supplements must be determined on an individual basis by the member’s PCP or specialty provider, using the criteria specified in this Policy. The PCP or specialty provider must use the AHCCCS approved form (AMPM 310-GG Attachment A) to obtain authorization from the AdSS.

A. Specific criteria must be met with AMPM 310-GG Attachment A when assessing the medical necessity of providing commercial oral nutritional supplements. These criteria include the following:

1. The Member is currently underweight with a BMI of less than 18.5, presenting serious health consequences for the member, or has already demonstrated a medically significant decline in weight within the past three months (prior to the assessment),

2. The Member is able to consume/eat no more than 25% of his/her nutritional requirements from typical food sources,

3. The Member has been evaluated and treated for medical conditions that may cause problems with weight gain and growth (e.g. feeding problems, behavioral conditions or psychosocial problems, endocrine or gastrointestinal problems), and

4. The Member has had a trial of higher caloric foods, blenderized foods, or commonly available products that may be used as dietary supplements for a period no less than 30 days in duration. If it is determined through clinical documentation and other supporting evidence that a trial of higher caloric foods would be detrimental to the member’s overall health, the provider may submit Attachment C, along with supporting documentation demonstrating the risk posed to the member for the AdSS Medical Director’s consideration in approving the provider’s PA request.
B. Supporting documentation must also accompany AMPM 310-GG Attachment A. This documentation must demonstrate that the member meets all of the required criteria and includes:

1. Initial Requests:
   a. Documentation demonstrating that nutritional counseling has been provided as a part of the health risk assessment and screening services provided to the member by the PCP or specialty provider, or through consultation with a registered dietitian,
   b. Clinical notes or other supporting documentation dated no earlier than three months prior to date of the request, providing a detailed history and thorough physical assessment and demonstrating evidence of the member meeting all of the required criteria listed in AMPM 310-GG Attachment A. The physical assessment must include the member’s current/past height, weight, and BMI,
   c. Documentation detailing alternatives that were tried in an effort to boost caloric intake and/or change food consistencies that have proven unsuccessful in resolving the nutritional concern identified, as well as member adherence to the prescribed dietary plan/alternatives attempted.

2. Ongoing Requests:
   a. Subsequent submissions must include a clinical note or other supporting documentation dated no earlier than three months prior to the date of the request, that includes the member’s overall response to supplemental therapy and justification for continued supplement use. This shall include the member’s tolerance, recent hospitalizations, current height, weight, and BMI,
   b. Documentation demonstrating encouragement and assistance provided to the caregiver in weaning the member from supplemental nutritional feedings should be included, when appropriate, and
   c. Members receiving nutritional therapy must be physically assessed by the member’s PCP, specialty provider, or registered dietitian at least annually.
   d. Initial and ongoing certificate of medical necessity is considered valid for a period of six month.

**Metabolic Medical Foods**

Metabolic medical foods are used to treat inherited metabolic disorders that are rare genetic conditions in which normal metabolic function is inhibited by a deficiency in a critical enzyme. Metabolic formula or modified low protein foods are produced or manufactured specifically for persons with a qualifying metabolic disorder and are not generally used by persons in the absence of a qualifying metabolic disorder.
A. Metabolic formulas and medical foods are covered within limitations specified in this Policy for members diagnosed with the following metabolic conditions: Phenylketonuria; Homocystinuria; Maple Syrup Urine Disease; Galactosemia (requires soy formula); Beta Keto-Thiolase Deficiency; Citrullinemia; Glutaric Acidemia Type I; Isovaleric Acidemia; Methylmalonic Acidemia; Propionic Acidemia; Argininosuccinic Acidemia; Tyrosinemia Type I; HMG CoA Lyase Deficiency; Very long chain acyl-CoA Dehydrogenase deficiency (VLCAD), and Long Chain acyl-CoA dehydrogenase deficiency (LCHAD).

1. The AdSS is responsible for the initial and follow-up consultations by a genetics physician and/or a metabolic nutritionist,

2. The AdSS is responsible for all medically necessary laboratory tests and other services related to the provision of medical formulas/foods for members diagnosed with an inherited metabolic disorder,

3. Metabolic formula or modified low protein foods shall be processed or formulated to be deficient in the nutrients(s) specific to the member’s metabolic condition; meet the member’s distinctive nutritional requirements; determined to be essential to sustain the member’s optimal growth within nationally recognized height/weight or BMI, and metabolic homeostasis; obtained under physician order; member’s medical and nutritional status shall be supervised by the member’s PCP, attending physician or appropriate specialist,

4. Modified low protein foods must be formulated to contain less than 1 gram of protein per unit or serving. For purposes of this policy, modified low protein foods do not include foods that are naturally low in protein,

5. Soy formula is covered only for members receiving Early and periodic Screening, Diagnosis and Treatment (EPSDT) services and only until members are able to eat solid lactose-free foods,

6. Foods that are available in the grocery store or health food store are not covered as a metabolic food, and

7. Education and training regarding proper sanitation and temperatures to avoid contamination of foods which are blended or specially prepared for the member is required, if the member/guardian/designated representative elects to prepare the member’s food.

Provider Requirements

A. When requesting initial or ongoing PA for supplemental nutrition, providers must provide the following:

1. A completed copy of AMPM 310-GG Attachment A to support all of the necessary requirements for Commercial Oral Nutritional Supplements as detailed in this Policy

2. Documentation of ongoing monitoring conducted to assess member

310-GG Nutritional Therapy, Metabolic Foods, and Total Parenteral Nutrition
adherence/ tolerance to the prescribed nutritional supplement regimen and any necessary adjustments.

3. The AdSS must implement protocols for transitioning a member who is receiving nutritional therapy to or from another AdSS or Provider.
310-HH  END OF LIFE CARE AND ADVANCE CARE PLANNING

EFFECTIVE DATE: October 1, 2019

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The Division provides oversight and monitoring of delegated duties.

This Policy establishes guidelines for the concept of End of Life (EOL) care and the provision of Advance Care Planning.

Definitions

A. **Advance Directive** - A document by which a person makes provision for health care decisions in the event that, in the future, he/she becomes unable to make those decisions.

B. **Advance Care Planning** - Advance care planning is a part of the End of Life care concept and is a billable service that is a voluntary face-to-face ongoing discussion between a qualified health care professional and the member to:

   1. Educate the member/guardian/designated representative(s) about the member’s illness and the health care options that are available to them.
   2. Develop a written plan of care that identifies the member’s choices for treatment.
   3. Share the member’s wishes with family, friends, and his or her physicians.

C. **Curative Care** - Health care practices that treat patients with the intent of curing them, not just reducing their pain or stress. An example is chemotherapy, which seeks to cure cancer patients.

D. **End-of-Life Care** - A concept of care, for the duration of the member’s life, that focuses on Advance Care Planning, the relief of stress, pain, or life limiting effects of illness to improve quality of life for a member at any age who is currently or is expected to experience declining health, or is diagnosed with a chronic, complex or terminal illness.

E. **Hospice Services** - A program of care and support for terminally ill members who meet the specified medical criteria/requirements.

F. **Practical Support** - Non-billable services provided to a member by a family member, friend or volunteer to assist or perform functions such as, but not limited to: housekeeping, personal care, food preparation, shopping, pet care, or non-medical comfort measures.

End of Life Care Concept

EOL care is member-centric care that includes Advance Care Planning, and the delivery of appropriate health care services and practical supports. The goals of End of Life care focuses on providing treatment, comfort, and quality of life for the duration of the member’s life. The EOL concept of care strives to ensure members achieve quality of life through the provision of services such as:
A. Physical and/or behavioral health medical treatment to:
   1. Treat the underlying illness and other comorbidities.
   2. Relieve pain.

B. Referrals to community resources for services such as, but not limited to:
   1. Pastoral/counseling services
   2. Legal services.

C. Practical supports are non-billable services provided by a family member, friend or volunteer to assist or perform functions such as, but not limited to:
   1. Housekeeping
   2. Personal Care
   3. Food preparation
   4. Shopping
   5. Pet care

Members aged 21 years and older who receive EOL care may continue to receive curative care until they choose to receive hospice care.

Members under the age of 21 may receive curative care concurrently with EOL care and hospice care.

**Advance Care Planning**

Advance Care Planning is initiated by the member’s qualified health care professional for a member at any age that is currently or is expected to experience declining health or is diagnosed with a chronic, complex or terminal illness. For the purposes of Advance Care Planning, a qualified health care professional is a MD, DO, PA, or NP. Advance Care Planning is meant to be an ongoing process for the duration of the member’s life.

**AHCCCS Medical Manual Section 310 – Covered Services**

Advance Care Planning often results in the creation of an Advance Directive for the member. Refer to AMPM Policy 640 for provider requirements pertaining to Advance Directives.

The AdSS must ensure providers perform the following as part of the EOL concept of care when treating qualifying members:

A. Conduct a face-to-face discussion with the member/guardian/designated representative to develop Advance Care Planning.

B. Teach the member/guardian/designated representative about the member’s illness
and the health care options that are available to the member to enable them to make educated decisions.

C. Identify the member’s healthcare, social, psychological and spiritual needs.

D. Develop a written member centered plan of care that identifies the member’s choices for care and treatment, as well as life goals.

E. Share the member’s wishes with family, friends, and his or her physicians.

F. Complete Advance Directives.

G. Refer to community resources based on member’s needs.

H. Assist the member/guardian/designated representative in identifying practical supports to meet the member’s needs.

AdSS must provide care management to qualifying members and coordinate with and support the member’s provider in meeting the member’s needs. In addition, the care manager will assist the member/guardian/designated representative in ensuring practical supports and community referrals are maintained or revised to meet the member’s current needs.

Advance Care Planning is a covered, reimbursable service when provided by a qualified health care professional. The provider may bill for providing Advance Care Planning separately during a well or sick visit.

**Hospice Services**

Refer to Division Medical Policy 310-J.

**Training**

AdSS must ensure providers and their staff are educated in the concepts of EOL care, Advance Care Planning and Advance Directives.

**Network Adequacy**

AdSS must ensure an adequate network of providers who are trained to conduct Advance Care Planning. Refer to Administrative Services Subcontractors Operations Manual, Policy 415.
320-H MEDICAL FOODS

EFFECTIVE DATE: October 1, 2019

Description of Benefit

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

A. Phenylketonuria
B. Homocystinuria
C. Maple Syrup Urine Disease
D. Galactosemia (requires soy formula)
E. Beta Keto-Thiolase Deficiency
F. Citrullinemia
G. Glutaric Acidemia Type I
H. 3 Methylcrotonyl CoA Carboxylase Deficiency
I. Isovaleric Acidemia
J. Methylmalonic Acidemia
K. Propionic Acidemia
L. Arginosuccinic Acidemia
M. Tyrosinemia Type I
N. HMG CoA Lyase Deficiency
O. Cobalamin A, B, C Deficiencies

Definitions

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

B. Metabolic Nutritionist - A provider registered with the Arizona Health Care Cost Containment System (AHCCCS) who is a registered dietitian specializing in nutritional assessment and treatment of metabolic conditions.
Conditions, Limitations and Exclusions

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

B. Metabolic formula and modified low-protein foods must be:
   1. Essential to sustain the member’s growth within nationally recognized height/weight or BMI (body mass index) levels, maintain health and support metabolic balance;
   2. Obtained only under physician order; and
   3. Supervised by the member’s PCP, attending physician or appropriate specialist for the medical and nutritional management of a member who has:
      a. Limited capacity to metabolize typical foods or certain nutrients contained in typical food; or
      b. Other specific nutrient requirements as established by medical evaluation.

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

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

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

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

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

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

EFFECTIVE DATE: October 1, 2019
REFERENCES: AMPM Policy 431; Social Security Act, Section 1905(a)

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

Definitions

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

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

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

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

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

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

1. Teledentistry includes the provision of preventive and other approved therapeutic services by the AHCCCS registered Affiliated Practice Dental Hygienist, who provides dental hygiene services under an affiliated practice relationship with a dentist.
2. Teledentistry does not replace the dental examination by the dentist; limited, periodic, and comprehensive examinations cannot be billed through the use of Teledentistry alone.

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

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

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

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

**Use of Telemedicine**

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

A. Cardiology
B. Dermatology
C. Endocrinology
D. Hematology/oncology
E. Infectious diseases
F. Neurology
G. Obstetrics/gynecology
H. Oncology/radiation
I. Ophthalmology
J. Orthopedics
K. Pain clinic
L. Pathology
M. Pediatrics and pediatric subspecialties
N. Radiology
O. Rheumatology
P. Surgery follow-up and consultations
Q. Behavioral Health
R. Diagnostic consultation and evaluation, including:
   1. Psychotropic medication adjustment and monitoring
   2. Individual and family counseling
   3. Case management

**Use of Telecommunications**

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

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

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

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

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

Conditions, Limitations and Exclusions

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

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

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

D. Nonemergency transportation to and from the telemedicine originating site to receive a medically necessary consultation or treatment service is covered.
320-O  BEHAVIORAL HEALTH ASSESSMENTS AND TREATMENT/SERVICE PLANNING

EFFECTIVE DATE: October 1, 2019

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). This policy describes the providing of for behavioral health assessment and treatment/service planning for members eligible for the Division.

Definitions

A. Behavioral Health Home - Contracted behavioral health provider that serves as an intake agency, provides or coordinates the provision of covered behavioral health services, and coordinates care with the primary care provider for adults and/or children with behavioral health needs.

B. Behavioral Health Professional (BHP) -

1. A person licensed under A.R.S. § 32-3251 et seq., who can:
   a. Independently engage in the practice of behavioral health as defined in A.R.S. § 32-3251 or
   b. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. § 32-3251 under direct supervision as defined in A.A.C. R4-6-101

2. A psychiatrist as defined in A.R.S. § 36-501

3. A psychologist as defined in A.R.S. § 32-2061

4. A physician

5. A behavior analyst as defined in A.R.S. § 32-2091

6. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse

7. A registered nurse.
C. **Behavioral Health Technician (BHT)** -

As specified in A.A.C. R9-10-101, a person who is not a BHP who provides behavioral health services at, or for, a health care institution according to the health care institution’s policies and procedures. A BHT is a person who:

1. If the behavioral health services were provided in a setting other than a licensed health care institution, would be required to be licensed as a behavioral professional under A.R.S. § 32-3251 et seq
2. Is provided with clinical oversight by a behavioral health professional.

D. **Specialty Provider** – A provider of a behavioral health service that is not available in the Behavioral Health Home.

E. **Treatment Plan** – A written description of covered health services and informal supports identified based on an assessment to assist the member in achieving an improved quality of life. This Plan must be incorporated into the Planning Document completed by the Support Coordinator.

**Overview**

The model for behavioral health assessment, treatment/service planning, and service delivery must be strength-based, member-centered, family-friendly, culturally and linguistically appropriate, and clinically supervised.

The model:

A. Is based on four components:

1. Input from the member/guardian/designated representative regarding his/her needs, strengths, and preferences
2. Input from other persons involved in the member’s care who have integral relationships with the member
3. Development of a therapeutic alliance between the member/guardian/designated representative and behavioral health provider that promotes an ongoing partnership built on mutual respect and equality
4. Clinical expertise/qualifications of person(s) conducting the assessment, treatment/service planning, and service delivery.

B. Incorporates the concept of a "team."

For children, this team is the Child and Family Team (CFT) and for adults, this team is the Adult Recovery Team (ART). At a minimum, the functions of the CFT and ART include:

1. Ongoing engagement of the member/guardian/designated representative,
family, assigned Support Coordinator and others who are significant in meeting the behavioral health needs of the member, including their active participation in the decision-making process and involvement in treatment. The member’s Support Coordinator must participate in all CFT and ART meetings.

2. An assessment process that:
   a. Elicits information on the strengths and needs of the member and his/her family
   b. Identifies the need for further or specialty evaluations
   c. Supports the development and updating of the treatment/service plan(s) which effectively meets the member’s/family’s needs and results in improved health outcomes.

3. Continuous evaluation of treatment effectiveness through the CFT or ART process, the ongoing assessment of the member, and input from the member/guardian/designated representative and Support Coordinator resulting in change to the treatment plan(s), as necessary.

4. Provision of all covered services as identified on the treatment/service plan(s), including assistance in accessing community resources as appropriate.

5. For children, services are provided consistent with the Arizona Vision - 12 Principles as outlined in Division Medical Policy Manual, Policy 430. For adults, services are provided consistent with the Adult Service Delivery System - 9 Guiding Principles.

6. Ongoing collaboration with other people and/or entities with whom delivery and coordination of services is important to achieving positive outcomes (e.g. primary care providers, specialty service providers, school, child welfare, Division of Developmental Disabilities (DDD), justice system and others). This must include sharing of clinical information as appropriate.

7. Ensure continuity of care by assisting members who are transitioning to a different treatment program, changing behavioral health providers and/or transferring to another service delivery system (e.g. out-of-area, out-of-state, or to a different AdSS). For more details, see Administrative Services Subcontractors Operations Manual Policy 402 and Division Medical Policy Manual, Policy 520.

**Assessment and Service Planning**

A. General Requirements:

1. Behavioral health assessments and treatment planning must comply with the Rules in A.A.C. R9-10 and A.A.C. R9-21, as applicable.
2. Behavioral health providers, including specialty providers, may engage in assessment and treatment planning activities to support timely access to medically necessary behavioral health services.

3. If the assessment is completed by the BHT, the requirements of A.A.C. R9-10-1011(B)(3) must be met.

4. At a minimum, the member/guardian/designated representative and a BHP must be included in the assessment process and development of the treatment/service plan.

5. The assessment and service plan must be included in the clinical record in accordance with Division Medical Policy Manual, Policy 940.

6. The service plan must be based on the current assessment and identify the specific services and supports to be provided.

7. The behavioral health provider must document whether or not the member/guardian/designated representative agrees with the service plan.

8. The member/guardian/designated representative must be provided with a copy of his/her service plan within seven calendar days of completion of the service plan and/or upon request.

9. Serious Mental Illness (SMI) Determination must be completed for members who request an SMI determination in accordance with AdSS Medical Policy Manual, Policy 320-P.

10. For members determined SMI:
   a. Assessment and treatment/service planning must be conducted in accordance with A.A.C. R9-21-301 et seq. and A.A.C. R9-21-401 et seq.
   b. Special Assistance assessment must be completed in accordance with Division Medical Policy Manual Policy 320-R.
   c. The completed treatment/service plan must be signed by the member/guardian/designated representative in accordance with A.A.C. R9-21-308.
   d. For appeal requirements, see A.A.C. R9-21-401 et seq. and Administrative Services Subcontractors Operations Manual Policy 444.

B. Additional Requirements:

1. The Behavioral Health Home must maintain the comprehensive assessment and conduct periodic assessment updates to meet the changing behavioral health needs for members who continue to receive behavioral health services.
2. Assessments must be updated at a minimum of once annually,

3. Assessments and treatment/service plans must be completed by BHPs or BHTs under the clinical oversight of a BHP that meets credentialing and training requirements outlined in Division Medical Policy Manual, Policy 950,

4. The Behavioral Health Home must maintain the treatment/service plan and conduct periodic treatment/service plan updates to meet the changing behavioral health needs for members who continue to receive behavioral health services,

5. Other qualified BHPs, including specialty providers not part of the behavioral health home, may engage in assessment and treatment/service planning activities to support timely access to medically necessary behavioral health services. These providers must provide completed assessment and treatment/service plan documentation to the Behavioral Health Home for inclusion in the comprehensive Behavioral Health Home clinical record. The AdSS may incorporate additional requirements, such as Behavioral Health Home referral expectations, as long as they do not prevent timely access to covered behavioral health services.

6. The Behavioral Health Home must coordinate with the member’s health plan, PCP, specialty providers, the designated Support Coordinator, and others involved in the care or treatment of the member (e.g. DCS, Probation), as applicable, regarding assessment and treatment/service planning see Division Medical Policy Manual, Policy 540.

7. Special Circumstances

   a. Children Age 0 to 5 – Developmental screening must be conducted by the Behavioral Health Home for children age 0-5 with a referral for further evaluation when developmental concerns are identified.

   b. Children Age 6 to 18 - The Child and Adolescent Service Intensity Instrument (CASII) must be completed by the Behavioral Health Home during the initial assessment and updated at least once annually.

   c. Children Age 6 to 18 - with CASII Score of four or Higher: Strength, Needs and Culture Discovery Document must be completed by the Behavioral Health Home.

   d. Children Age 11 to 18 - Standardized substance use screen and referral for further evaluation when screened positive must be completed by the Behavioral Health Home.
320-P    SERIOUS MENTAL ILLNESS ELIGIBILITY DETERMINATION

EFFECTIVE DATE: October 1, 2019

This policy applies to the Division of Developmental Disabilities’ (Division) Administrative Services Subcontractors (AdSS). The Division contracts with the AdSS and delegates the responsibilities of implementing this policy. The Division provides oversight and monitoring of delegated duties.

Policy Overview

A critical component of the AHCCCS delivery system is the effective and efficient identification of individuals who have behavioral health needs due to the severity of their behavioral health disorder. One such group is individuals determined to have a serious mental illness (SMI). Without receipt of the appropriate care, these individuals are at high risk for further deterioration of their physical and mental condition, increased hospitalizations, and potential homelessness and incarceration. To ensure that individuals who may have an SMI are promptly identified and evaluated, AHCCCS has established a standardized process for the referral, evaluation and determination of SMI eligibility as set forth in this Policy. The Division has adopted Exhibits from AHCCCS AMPM Policy 320-P for use by the AdSS.

Definitions

**Assessment:** The ongoing collection and analysis of an individual’s medical, psychological, psychiatric and social conditions in order to initially determine if a health disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensure that the individual’s service plan is designed to meet the individual’s (and family’s) current needs and long term goals.

**Evaluation:** The process of analyzing current and past treatment information, including assessment, treatment, other medical records and documentation, for purpose of determining an individual’s eligibility for SMI services.

**Day:** Computation of Time as defined in A.A.C. R9-21-103.

**Determining Entity:** The AHCCCS designee authorized to make the determination of SMI eligibility.

**Serious Mental Illness:** A designation as defined in A.R.S. §36-550 and determined in an individual 18 years of age or older.

**Seriously Mentally Ill (SMI):** Individuals who, as a result of a mental disorder as defined in A.R.S. 36-501, exhibit emotional or behavioral functioning that is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. In these individuals’ mental disability is severe and persistent, resulting in a long-term limitation of their functional capacities for primary activities of daily living such as interpersonal relationships, homemaking, self-care, employment and recreation.

**SMI Determination:** A determination as to whether or not an individual meets the diagnostic
and functional criteria established for the purpose of determining an individual’s eligibility for SMI services.

**SMI Decertification:** The process that results in a modification to a member’s medical record by changing the behavioral health category designation from SMI to General Mental Health.

**A. General Requirements**

1. All individuals must be evaluated for SMI eligibility by a qualified clinician, as defined in A.A.C. R9-21-101(B), and have an SMI Determination made by the Determining Entity if:
   a. The individual makes such a request;
   b. A guardian/legal representative, who is authorized pursuant to A.R.S. 14-5312, makes a request on behalf of the individual;
   c. An Arizona Superior Court issues an order instructing that an individual is to undergo an SMI Evaluation/determination; or
   d. A member is at least the age of 17.5. (Refer to AHCCCS Transition to Adulthood Practice Tool 8.0.)

2. The SMI eligibility evaluation record must contain all documentation considered during the review, including but not limited to, current and/or historical treatment records. The record may be maintained in either hardcopy or electronic format. The AdSS shall develop and make available to providers any requirements or guidance on SMI eligibility evaluation record location and/or maintenance.

3. Computation of time is as follows:
   a. Day Zero: The day the initial assessment is completed by a qualified clinician, regardless of time of the assessment;
   b. Day One: The next business day after the initial assessment is completed. The individual or organization completing the initial assessment must provide it to the Determining Entity as soon as practicable, but no later than 11:59 pm on Day One;
   c. Day Three: The third business day after the initial assessment is completed. The Determining Entity shall have at least two business days to complete the final SMI Determination, but the final SMI Determination must be completed no later than Day Three; and
   d. Determination Due Date: Day Three, three business days after Day Zero, excluding weekends and holidays, and is the date that the determination decision must be rendered. This date may be amended if an extension is approved in accordance with this policy.
B. Process for Completion of Initial SMI Evaluation

1. Upon receipt of a request, referral, or identification of the need for an SMI Determination, the AdSS will schedule an appointment for an initial meeting with the individual and a qualified clinician. This shall occur no later than seven business days after receiving the request or referral.

2. For referrals seeking an SMI eligibility determination for individuals admitted to a hospital for psychiatric reasons the entity scheduling the evaluation shall ensure that documented efforts are made to schedule a face-to-face SMI assessment with the member while hospitalized.

3. During the initial SMI evaluation meeting with the individual and qualified clinician, the clinician must:
   a. Make a clinical judgement as to whether the individual is competent enough to participate in an Evaluation;
   b. Obtain written consent to conduct the assessment from the individual or, if applicable, the individual’s guardian, unless the individual is under court-ordered evaluation as part of court-ordered treatment proceedings;
   c. Provide the individual and, if applicable, the individual’s guardian, the information required in A.A.C. R9-21-301(D)(2), a client rights brochure, and the appeal notice required by A.A.C. R9-21-401(B);
   d. Obtain authorization for the release of information, if applicable, (see AMPM Policy 550) for any documentation that would assist in the determination of the individual’s eligibility for SMI services;
   e. Conduct an assessment if one has not been completed within the last six months;
   f. Complete the SMI Determination Form (see AMPM 320-P Attachment A; and
   g. Upon completion of the initial SMI evaluation, submit all information to the Determining Entity within one business day.

C. Criteria for SMI Eligibility

1. The final determination of SMI requires both a qualifying SMI diagnosis and functional impairment because of the qualifying diagnosis (see AMPM 320-P Attachment B for qualifying diagnoses).

2. To meet the functional criteria for SMI status, an individual must have, as a result of a qualifying SMI diagnosis, dysfunction in at least one of the four domains described below for most of the past twelve months or for most of the past six months with an expected continued duration of at least six months:
   a. Inability to live in an independent or family setting without
supervision. 

Neglect or disruption of ability to attend to basic needs. Needs assistance in caring for self. Unable to care for self in safe or sanitary manner. Housing, food and clothing must be provided or arranged for by others. Unable to attend to the majority of basic needs of hygiene, grooming, nutrition, medical and dental care. Unwilling to seek prenatal care or necessary medical/dental care for serious medical or dental conditions. Refuses treatment for life threatening illnesses because of behavioral health disorder;

b. A risk of serious harm to self or others. Seriously disruptive to family and/or community. Pervasively or imminently dangerous to self or others’ bodily safety. Regularly engages in assaultive behavior. Has been arrested, incarcerated, hospitalized or at risk of confinement because of dangerous behavior. Persistently neglectful or abusive towards others in the individual’s care. Severe disruption of daily life due to frequent thoughts of death, suicide, or self-harm, often with behavioral intent and/or plan. Affective disruption causes significant damage to the individual’s education, livelihood, career, or personal relationships;

c. Dysfunction in role performance. Frequently disruptive or in trouble at work or at school. Frequently terminated from work or suspended/expelled from school. Major disruption of role functioning. Requires structured or supervised work or school setting. Performance significantly below expectation for cognitive/developmental level. Unable to work, attend school, or meet other developmentally appropriate responsibilities.

d. Risk of Deterioration. If an individual does not meet any one of the above functional criteria, and is expected to deteriorate to such a level without treatment, SMI eligibility may be established based on any of the following criteria:

i. A qualifying diagnosis with probable chronic, relapsing and remitting course;

ii. Co-morbidities (e.g., developmental/intellectual disability, substance use disorder, personality disorders);

iii. Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors (e.g., life-threatening or debilitating medical illnesses, victimization); or

iv. Other (e.g., past psychiatric history, gains in functioning have not solidified or are a result of current compliance only, court-committed, care is complicated and requires multiple providers).

3. The following reasons are not sufficient alone for denial of SMI eligibility:

a. An inability to obtain existing records or information; or
b. Lack of a face-to-face psychiatric or psychological evaluation.

D. Process for Completion of Final SMI Determination

1. The AdSS shall develop policies and procedures that describe the providers’ requirements for submitting the Evaluation Packet and providing additional clinical information in order for the Determining Entity to make the final SMI eligibility determination.

2. If the Determining Entity requires additional information to make a final SMI eligibility determination, the AdSS shall ensure that evaluating agencies respond to the Determining Entity within three business days of the request for information.

3. The licensed psychiatrist, psychologist or nurse practitioner designated by the Determining Entity will make a final determination as to whether the individual meets the eligibility requirements for SMI status based on:
   a. A face-to-face assessment or reviewing a face-to-face assessment by a qualified clinician; and
   b. A review of current and historical information, if any, obtained orally or in writing by the assessor from collateral sources, and/or present or previous treating clinicians.

4. The following shall occur if the designated reviewing psychiatrist, psychologist or nurse practitioner has not conducted a face-to-face assessment and has a disagreement with the current evaluating or treating qualified behavioral health professional or behavioral health technician that cannot be resolved by oral or written communication:
   a. Disagreement regarding diagnosis: Determination that the individual does not meet eligibility requirements for SMI status must be based on a face-to-face diagnostic evaluation conducted by a designated psychiatrist, psychologist or nurse practitioner. The resolution of (specific reasons for) the disagreement must be documented in the individual’s comprehensive clinical record.
   b. Disagreement regarding functional impairment: Determination that the individual does not meet eligibility requirements must be documented by the psychiatrist, psychologist or nurse practitioner in the individual’s comprehensive clinical record to include the specific reasons for the disagreement and will include a clinical review with the qualified clinician.

5. If there is sufficient information to determine SMI eligibility, the individual shall be provided written notice of the SMI eligibility determination within three business days of the initial meeting with the qualified clinician in accordance with this Policy.
E. **Issues Preventing Timely Completion of SMI Eligibility Determination Extending Completion of SMI Eligibility Time Period**

1. The time to initiate or complete the SMI eligibility determination may be extended no more than 20 calendar days if the individual agrees to the extension and:

   a. There is substantial difficulty scheduling a meeting in which all necessary participants can attend;
   
   b. The individual fails to keep an appointment for assessment, evaluation or any other necessary meeting;
   
   c. The individual is capable of, but temporarily refuses to cooperate in the preparation of the completion of an assessment or evaluation;
   
   d. The individual or the individual’s guardian and/or designated representative requests an extension of time;
   
   e. Additional documentation has been requested but not received; or
   
   f. There is insufficient functional or diagnostic information to determine SMI eligibility within the required time periods.

**NOTE:** Insufficient diagnostic information shall be understood to mean that the information available to the reviewer is suggestive of two or more equally likely working diagnoses, only one of which qualifies as SMI, and an additional piece of existing historical information or a face-to-face psychiatric evaluation is likely to support one diagnosis more than the other(s).

2. The Determining Entity must:

   a. Document the reasons for the delay in the individual’s eligibility determination record when there is an administrative or other emergency that will delay the determination of an SMI status, and
   
   b. Not use the delay as a waiting period before determining an SMI status or as a reason for determining that the individual does not meet the criteria for SMI eligibility (because the determination was not made within the time standards).

3. In situations in which the extension is due to insufficient information:

   a. The Determining Entity shall request and obtain the additional documentation needed (e.g., current and/or past medical records) and/or perform or obtain any necessary psychiatric or psychological evaluations;
   
   b. The designated reviewing psychiatrist, psychologist or nurse practitioner must communicate with the individual’s current treating clinician, if any, prior to the determination of an SMI, if there is insufficient information to determine the individual’s level of functioning; and
c. SMI eligibility must be determined within three days of obtaining sufficient information, but no later than the end date of the extension.

4. If the evaluation or information cannot be obtained within the required time period because of the need for a period of observation or abstinence from substance use in order to establish a qualifying mental health diagnosis, the individual shall be notified by the Determining Entity that the determination may, with the agreement of the individual, be extended for up to 90 calendar days for an Extended Evaluation Period. This is a 90-day period of abstinence from drug and/or alcohol use in order to help the reviewing psychologist make an informed decision regarding SMI eligibility. This extension may be considered a technical re-application to ensure compliance with the intent of A.A.C. R9-21-303; however, the individual does not need to actually reapply. Alternatively, the determination process may be suspended and a new application initiated upon receipt of necessary information.

5. If the individual refuses to grant an extension, SMI eligibility must be determined based on the available information. If SMI eligibility is denied, the individual will be notified of his/her appeal rights and the option to reapply in accordance with this Policy.

F. Notification of SMI Eligibility Determination

1. If the individual is determined SMI, the SMI status must be reported to the individual or legal guardian, by the Determining Entity, in writing, including notice of the individual’s right to appeal the decision.

2. If the eligibility determination results in a denial of SMI status, the Determining Entity must provide written notice of the decision and include:
   a. The reason for denial of SMI eligibility,
   b. The right to appeal, and
   c. The statement that individuals who are ALTCS eligible will continue to receive needed ALTCS covered services. In such cases, the individual's behavioral health category assignment must be assigned based on criteria in the AHCCCS Technical Interface Guidelines.

G. Re-enrollment or Transfer

1. If the individual’s status is SMI at disenrollment or transition to another AdSS or acute contractor, the individual's status shall continue as SMI.

2. An individual shall retain his/her SMI status unless a determination is made by a Determining Entity that the individual no longer meets criteria.

H. Review of SMI Eligibility

1. The AdSS must indicate in policies and procedures made available to their providers the process for reviewing an SMI eligibility determination.
2. The AdSS may seek a review of an individual's SMI eligibility from the Determining Entity:
   a. As part of an instituted, periodic review of all individuals determined to have an SMI;
   b. When there has been a clinical assessment that supports that the individual no longer meets the functional and/or diagnostic criteria; or
   c. As requested by a member, who has been determined to meet SMI eligibility criteria, or his/her legally authorized representative.

3. A review of the determination may not be requested by the AdSS or their contracted behavioral health providers within six months from the date an individual has been determined SMI eligible.

I. **SMI Decertification**

There are two established methods for removing an SMI designation, one clinical and the other an administrative option, as follows:

1. A member who has an SMI designation or an individual from the member’s clinical team may request an SMI Clinical Decertification from the AHCCCS designee that conducts SMI Determinations. An SMI Clinical Decertification is a determination that a member who has an SMI designation no longer meets SMI criteria. If, as a result of a review, the individual is determined to no longer meet the diagnostic and/or functional requirements for SMI status:
   a. The Determining Entity must ensure that written notice of the determination and the right to appeal is provided to the affected individual with an effective date of 30 calendar days after the date the written notice is issued, and
   b. The AdSS must ensure that services are continued if an appeal is timely filed, and that services are appropriately transitioned as part of the discharge planning process.

2. A member who has an SMI designation may request an SMI Administrative Decertification from AHCCCS, DHCM, and Clinical Resolution Unit if the member has not received behavioral health services for a period of two or more years.
   a. Upon receipt of a request for Administrative Decertification, the AdSS shall direct the member to contact AHCCCS, DHCM, Customer Service, and
   b. AHCCCS will evaluate the member’s request and review data sources to determine the last date the member received a behavioral health service. AHCCCS will inform the member of changes that may result with the removal of the member’s SMI designation. Based upon review, the following will occur:
i. If the member has not received a behavioral health service within the previous two years, the member will be provided with AMPM 320-P Attachment C. This form must be completed by the member and returned to AHCCCS; or

ii. If the review finds that the member has received behavioral health services within the prior two-year period, the member will be notified that he/she may seek Decertification of his/her SMI status through the Clinical Decertification process.
320-Q GENERAL AND INFORMED CONSENT

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. § 8-514.05(C), A.R.S. § 15-104, A.R.S. § 36-501 et seq, A.R.S. § 36-2272; A.A.C. R9-21-206.01(c); AMPM Policy 310-V; AMPM 310-V, Attachment A; AMPM Exhibit 320-Q, Attachments A and B

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). Each member of the Division of Developmental Disabilities (Division) has the right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment. It is important for members seeking behavioral health services to agree to those services, be made aware of the service options and alternatives available to them, and to be aware of the specific risks and benefits associated with these services.

Definitions

General Consent - a one-time agreement to receive certain services, including but not limited to behavioral health services, that is usually obtained from a member during the intake process at the initial appointment and is always obtained prior to the provision of any behavioral health services. General consent must be obtained from the member/responsible person.

Informed Consent - permission granted in the knowledge of the possible consequences; typically consent that is given by a patient to a doctor for treatment with full knowledge of the possible risks and benefits. Informed consent is required to be obtained from a member/responsible person prior to the provision of the following services and procedures:

A. Complementary and Alternative Medicine (CAM)
B. Psychotropic medications
C. Electro-Convulsive Therapy (ECT)
D. Use of telemedicine
E. Application for a voluntary evaluation
F. Research
G. Admission for medical detoxification, an inpatient facility or a residential program (for members determined to have a Serious Mental Illness)
H. Procedures or services with known substantial risks or side effects.

Overview

The Division and AHCCCS recognizes two primary types of consent for behavioral health services: general consent and informed consent.

Prior to obtaining informed consent, an appropriate behavioral health representative, as identified in A.A.C. R9-21-206.01(c), must present the facts necessary for a
member/responsible person to make an informed decision regarding whether to agree to the specific treatment and/or procedures. Documentation that the required information was given and that the member/responsible person agrees or does not agree to the specific treatment, and the member's/responsible person's signature when required, must be included in the comprehensive clinical record.

In addition to general and informed consent for treatment, state statute (A.R.S. § 15-104) requires written consent from a child’s parent or legal guardian for any behavioral health survey, analysis, or evaluation conducted in reference to a school based prevention program.

The intent of this section is to describe the requirements for reviewing and obtaining general, and informed consent, for members receiving services within the behavioral health system, as well as consent for any behavioral health survey or evaluation in connection with an AHCCCS school-based prevention program.

**General Requirements**

A. Any member, aged 18 years and older, in need of behavioral health services, must give voluntary general consent to treatment, demonstrated by the member’s or legal guardian’s signature on a general consent form, before receiving behavioral health services.

B. For members under the age of 18, the parent, legal guardian, or a lawfully authorized custodial agency (including foster care givers A.R.S. § 8-514.05[C]) must give general consent to treatment, demonstrated by the parent, legal guardian, or a lawfully authorized custodial agency representative’s signature on a general consent form prior to the delivery of behavioral health services.

C. Any member aged 18 years and older or the member’s legal guardian, or in the case of members under the age of 18, the parent, legal guardian or a lawfully authorized custodial agency, after being fully informed of the consequences, benefits and risks of treatment, has the right not to consent to receive behavioral health services.

D. Any member aged 18 years and older or the member’s legal guardian, or in the case of members under the age of 18, the parent, legal guardian or a lawfully authorized custodial agency has the right to refuse medications unless specifically required by a court order or in an emergency situation.

E. Providers treating members in an emergency are not required to obtain general consent prior to the provision of emergency services. Providers treating members pursuant to court order must obtain consent, as applicable, in accordance with A.R.S. § 36-501 et seq.

F. All evidence of informed consent and general consent to treatment must be documented in the comprehensive clinical record per Policy 940 of this Policy Manual.

G. The Administrative Services Subcontractor (AdSS) must develop and make available to providers policies and procedures that include any additional information or forms.

H. A foster parent, group home staff, foster home staff, relative, or other person or
agency in whose care a child is currently placed may give consent for:

1. Evaluation and treatment for emergency conditions that are not life threatening, and

2. Routine medical and dental treatment and procedures, including Early Periodic Screening Diagnosis and Treatment (EPSDT) services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (A.R.S. § 8-514.05[C]).

I. To ensure timely delivery of services, consent for intake and routine behavioral health services may be obtained from either the foster caregiver or the Department of Child Safety Specialist (DCSS), whomever is available to do so immediately upon request (A.R.S. § 8-514.05[C]).

J. Foster or kinship caregivers can consent to evaluation and treatment for routine medical and dental treatment and procedures, including behavioral health services. Examples of behavioral health services for which foster or kinship caregivers can consent include:

1. Assessment and service planning
2. Counseling and therapy
3. Rehabilitation services
4. Medical Services
5. Psychiatric evaluation
6. Psychotropic medication
7. Laboratory services
8. Support Services
9. Case Management
10. Personal Care Services
11. Family Support
12. Peer Support
13. Respite
14. Sign Language or Oral Interpretive Services
15. Transportation
16. Crisis Intervention Services
17. Behavioral Health Day Programs.

K. A foster parent, group home staff, foster home staff, relative, or other person or agency in whose care a child is currently placed must not consent to:

1. General anesthesia
2. Surgery
3. Testing for the presence of the human immunodeficiency virus
4. Blood transfusions
5. Abortions.

L. Foster or kinship caregivers may not consent to terminate behavioral health treatment. The termination of behavioral health treatment requires DCS consultation and agreement.

M. If the foster or kinship caregiver disagrees on the behavioral health treatment being recommended through the Child and Family Team (CFT), the CFT including the foster or kinship caregiver and DCS caseworker should reconvene and discuss the recommended treatment plan. Only DCS can refuse consent to medically recommended behavioral health treatment.

**General Consent**

Administrative functions associated with a member’s enrollment do not require consent, but before any services are provided, general consent must be obtained.

The AdSS must develop and make available to providers any form used to obtain general consent to treatment.

**Informed Consent**

A. In all cases where informed consent is required by this policy, informed consent must include at a minimum:

1. The member’s right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions
2. Information about the member’s diagnosis and the proposed treatment, including the intended outcome, nature and all available procedures involved in the proposed treatment
3. The risks, including any side effects, of the proposed treatment, as well as the risks of not proceeding
4. The alternatives to the proposed treatment, particularly alternatives offering less risk or other adverse effects

5. The ability of any consent given to be withheld or withdrawn in writing or orally at any time (when this occurs, the provider must document the member’s choice in the medical record)

6. The potential consequences of revoking the informed consent to treatment

7. A description of any clinical indications that might require suspension or termination of the proposed treatment.

B. Documenting Informed Consent

1. Members, or if applicable, the member’s parent, guardian or custodian, must give informed consent for treatment by signing and dating an acknowledgment that he or she has received the information and gives informed consent for the proposed treatment.

2. When informed consent is given by a third party, the identity of the third party and the legal capability to provide consent on behalf of the member, must be established. If the informed consent is for psychotropic medication or telemedicine and the member, or if applicable, the responsible person, refuses to sign an acknowledgment and gives verbal informed consent, the medical practitioner must document in the member’s record that:

   a. The information was given
   
   b. The member refused to sign an acknowledgment
   
   c. The member gives informed consent to use psychotropic medication or telemedicine.

C. When providing information that forms the basis of an informed consent decision for the circumstances identified above, the information must be:

1. Presented in a manner that is understandable and culturally appropriate to the member, parent, legal guardian or an appropriate court

2. Presented by a credentialed behavioral health medical practitioner or a registered nurse with at least one year of behavioral health experience.

   It is preferred that the prescribing clinician provide information forming the basis of an informed consent decision. In specific situations in which it is not possible or practicable, information may be provided by another credentialed behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience.
D. Psychotropic Medications, Complementary and Alternative Treatment and Telemedicine

1. Unless treatments and procedures are court ordered, providers must obtain written informed consent, and if written consent is not obtainable, providers must obtain oral informed consent. If oral informed consent is obtained instead of written consent from the member, parent or legal guardian, it must be documented in the medical record. Informed consent is required prior to:

   a. Initiation of any psychotropic medication or initiation of Complementary and Alternative Treatment (CAM) (see Division Medical Policy Manual Policy 310-V)

      The use of Informed Consent/Assent for Psychotropic Medication Treatment Form (AMPM 310-V Attachment A) is recommended as a tool to review and document informed consent for psychotropic medications.

   b. Delivery of behavioral health services through telemedicine.

2. Written informed consent must be obtained from the member, parent or legal guardian, unless treatments and procedures are under court order, prior to:

   a. Provision of Electro-Convulsive Therapy (ECT)

      ECT includes research activities, voluntary evaluation, and procedures or services with known substantial risks or side effects.

   b. Involvement of the member in research activities

   c. Provision of a voluntary evaluation for a member

      The use of Application for Voluntary Evaluation (AMPM 320-Q, Attachment A) is required for members determined to have a Serious Mental Illness and is recommended as a tool to review and document informed consent for voluntary evaluation of all other populations.

   d. Delivery of any other procedure or service with known substantial risks or side effects.

E. Written informed consent must be obtained from the member, legal guardian, or an appropriate court, prior to the member's admission to any medical detoxification program, inpatient facility, or residential program, operated by a behavioral health provider.

F. If informed consent is revoked, treatment must be promptly discontinued, except when abrupt discontinuation of treatment may pose an imminent risk to the member. In such cases, treatment may be phased out to avoid any harmful effects.
G. Informed Consent for Telemedicine

1. Before a health care provider delivers health care via telemedicine, verbal or written informed consent from the member or legally authorized health care decision maker must be obtained. Refer to this Policy Manual, Policy 320-I.

2. Information regarding informed consent may be provided by the behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience. When providing information regarding informed consent, it must be communicated in a manner that the member and/or legal guardian can adequately understand.

3. Exceptions to this consent requirement include:
   a. If the telemedicine interaction does not take place in the physical presence of the member
   b. In an emergency situation in which the member or the member’s legally authorized health care decision maker is unable to give informed consent
   c. The transmission of diagnostic images to a health care provider serving as a consultant or the reporting of diagnostic test results by that consultant.

Special Requirements for Children

A. In accordance with A.R.S. § 36-2272, except as otherwise provided by law or a court order, no person, corporation, association, organization, state-supported institution, or any person employed by any of these entities, may procure, solicit to perform, arrange for the performance of, or perform, mental health screening in a nonclinical setting or mental health treatment on a minor without first obtaining consent of a parent or a legal custodian of the minor child. If the parental consent is given through telemedicine, the health professional must verify the parent’s identity at the site where the consent is given. This section does not apply when an emergency exists that requires a person to perform mental health screening or provide mental health treatment to prevent serious injury to or save the life of a minor child.

B. Non-Emergency Situations

1. When the parent is unavailable to provide general or informed consent and the child is being supervised by a caregiver who is not the child’s legal guardian (e.g., grandparent) and does not have power of attorney, general and informed consent must be obtained from one of the following:
   a. Lawfully authorized legal guardian
   b. Foster parent, group home staff or other person with whom the DCS has placed the child, or
c. Government agency authorized by the court.

2. If someone other than the child’s parent intends to provide general and, when applicable, informed consent to treatment, the following documentation must be obtained and filed in the child’s comprehensive clinical record:

<table>
<thead>
<tr>
<th>INDIVIDUAL/ENTITY</th>
<th>DOCUMENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal guardian</td>
<td>Copy of court order assigning custody</td>
</tr>
<tr>
<td>Relatives</td>
<td>Copy of power of attorney document</td>
</tr>
<tr>
<td>Other person/agency</td>
<td>Copy of court order assigning custody</td>
</tr>
<tr>
<td>DCS Placements (for children removed from the home by DCS), such as:</td>
<td>None required (see note)</td>
</tr>
<tr>
<td>Foster parents</td>
<td></td>
</tr>
<tr>
<td>Group home staff</td>
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<tr>
<td>Foster home staff</td>
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<tr>
<td>Relatives</td>
<td></td>
</tr>
<tr>
<td>Other person/agency in whose care DCS has placed the child</td>
<td></td>
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</tbody>
</table>

Note: If behavioral health providers doubt whether the person bringing the child in for services is a person/agency representative in whose care DCS has placed the child, the provider may ask to review verification, such as documentation given to the person by DCS indicating that the person is an authorized DCS placement. If the person does not have this documentation, the provider may also contact the child’s DCS caseworker to verify the person’s identity.

3. For any child who has been removed from the home by DCS, the foster parent, group home staff, foster home staff, relative or other person or agency in whose care the child is currently placed may give consent for the following behavioral health services:

a. Evaluation and treatment for emergency conditions that are not life threatening, and

b. Routine medical and dental treatment and procedures, including early periodic screening, diagnosis and treatment services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (including behavioral health services and psychotropic medications).
4. Any minor who has entered into a lawful contract of marriage, whether or not that marriage has been dissolved subsequently, any emancipated youth or any homeless minor may provide general and, when applicable, informed consent to treatment without parental consent (A.R.S. § 44-132).

C. Emergency Situations

1. In emergencies involving a child in need of immediate hospitalization or medical attention, general and, when applicable, informed consent to treatment is not required.

2. Any child, 12 years of age or older, who is determined upon diagnosis of a licensed physician, to be under the influence of a dangerous drug or narcotic, not including alcohol, may be considered an emergency situation and can receive behavioral health care as needed for the treatment of the condition without general and, when applicable, informed consent to treatment.

Special Requirements for Children

At times, involuntary treatment can be necessary to protect safety and meet needs when a member, due to mental disorder, is unwilling or un-able to consent to necessary treatment. In this case, a court order may serve as the legal basis to proceed with treatment. However, capacity to give informed consent is situational, not global, as a member may be willing and able to give informed consent for aspects of treatment even when not able to give general consent. Members should be assessed for capacity to give informed consent for specific treatment, and such consent should be obtained if the member is willing and able, even though the member remains under court order.

Consent for Behavioral Health Survey or Evaluation for School-Based Prevention Programs

A. Written consent must be obtained from a child’s parent or legal guardian for any behavioral health survey, analysis, or evaluation conducted in reference to a school-based prevention program administered by AHCCCS.

B. Substance Abuse Prevention Program and Evaluation Consent (AMPM 320-Q, Attachment B) must be used to gain parental consent for evaluation of school based prevention programs. Providers may use an alternative consent form only with the prior written approval of the Division and AHCCCS. The consent must satisfy all of the following requirements:

1. Contain language that clearly explains the nature of the screening program and when and where the screening will take place

2. Be signed by the child’s parent or legal guardian

3. Provide notice that a copy of the actual survey, analysis, or evaluation questions to be asked of the student is available for inspection upon request by the parent or legal guardian.
C. Completion of Substance Abuse Prevention Program and Evaluation Consent (AMPM 320-Q, Attachment B) applies solely to consent for a survey, analysis, or evaluation only, and does not constitute consent for participation in the program itself.
320-R SPECIAL ASSISTANCE FOR MEMBERS WITH SERIOUS MENTAL ILLNESS

EFFECTIVE DATE: October 1, 2019

REFERENCES: AMPM Policy 1040; AMPM 320-R Attachment A; A.R.S. §§ 14-5304, 36-107, 36-501, 36-504, 36-509, 36-517.01, 41-3803, and 41-3804; 9 A.A.C 21

DELIVERABLES: Members Determined to Have SMI Receiving Special Assistance

This policy applies to the Division Administrative Services Subcontractor (AdSS). The Division’s AdSS must identify and report, to the Division, persons determined to have a Serious Mental Illness (SMI) and meet the criteria for Special Assistance.

If the person’s Special Assistance needs appear to be met by an involved family member, friend, designated representative, or guardian:

A. The AdSS, or a behavioral health provider, must still submit a notification to the Division.

B. The AdSS, must ensure that the person designated to provide Special Assistance is involved at key stages.

Purpose

The purpose of this policy is to establish uniform guidelines for:

A. Identifying persons determined to have a Serious Mental Illness (SMI) who are in need of Special Assistance

B. Ensuring that persons in need of Special Assistance have their Special Assistance needs met

C. Maintaining and disseminating required reports on persons in need of Special Assistance.

The AdSS must ensure that all subcontracted providers adhere to the requirements of this policy.

General Requirements

A. Criteria to deem a person to be in need of Special Assistance are as follows:

1. A person determined to have a Serious Mental Illness (SMI) is in need of Special Assistance if he/she is also unable to do any of the following:

   a. Communicate preferences for services.

   b. Participate effectively in Planning Meetings, or Inpatient Treatment Discharge Planning (ITDP).

   c. Participate effectively in the appeal, grievance or investigation processes.
d. The member’s limitations described in a.-c. above must also be due to any of the following:

i. Cognitive ability/intellectual capacity (i.e., cognitive impairment, borderline intellectual functioning, or diminished intellectual capacity)

ii. Language barrier (an inability to communicate, other than a need for an interpreter/translator)

iii. Medical condition (including, but not limited to traumatic brain injury, dementia, or severe psychiatric symptoms).

2. A person who is subject to general guardianship has been found to be incapacitated under A.R.S. § 14-5304, and therefore automatically satisfies the criteria for Special Assistance.

B. For a person determined to have an SMI, the existence of any of the following circumstances should prompt the AdSS to more closely review whether the person is in need of Special Assistance:

1. Developmental disability involving cognitive ability

2. Residence in a 24 hour setting

3. Limited guardianship, or the AdSS is recommending and/or pursuing the establishment of a limited guardianship

4. Existence of a serious medical condition that affects his/her intellectual and/or cognitive functioning (such as, dementia or traumatic brain injury).

C. Any of the following people may deem a person to be in need of Special Assistance:

1. A qualified clinician providing treatment for the person

2. A Support Coordinator

3. A clinical team of the AdSS

4. The Division/Division Planning Team

5. A program director of an AdSS-subcontracted provider (including the Arizona State Hospital [AzSH])

6. The Deputy Director of AHCCCS or designee

7. A hearing officer assigned to an appeal involving a person determined to have an SMI.
D. When to Screen for Special Assistance

The AdSS, and their subcontracted providers must, on an ongoing basis, screen whether persons determined to have an SMI are in need of Special Assistance in accordance with the criteria set out in the General Requirements section of this policy. Minimally, this must occur at the following stages:

1. Assessment and annual updates
2. Development of, or update to, the Behavioral Health Individual Service Plan (ISP)
3. Upon admission to a psychiatric inpatient facility
4. Development of, or update to, an Inpatient Treatment and Discharge Plan (ITDP)
5. Initiation of the grievance or investigation processes
6. Filing of an appeal
7. Existence of a condition that may be a basis for a grievance, investigation or an appeal.

Documentation

A. The AdSS, and their subcontracted providers must document in the clinical record each time a staff member screens a person for Special Assistance, indicating the factors reviewed and the conclusion. If the conclusion is that the person is in need of Special Assistance, they must notify the Division, using AHCCCS Medical Policy Manual (AMPM) 320-R Attachment A, Notification of Member in Need of Special Assistance, as adopted by the Division, in accordance with the procedures below.

B. Before submitting AMPM 320-R Attachment A, the AdSS, and their subcontracted providers must check if the person is already identified as in need of Special Assistance. A notation of Special Assistance designation and a completed AMPM 320-R Attachment A should already exist in the clinical record. However, if it is unclear, subcontracted providers must review data or contact the AdSS to inquire about current status.

C. The AdSS are required to maintain a database on persons in need of Special Assistance and share data with providers on a regular basis (at a minimum quarterly).

Requirements to Notify the Division

A. If a person is not correctly identified as Special Assistance, the AdSS, and their subcontracted providers, must submit Part A of AMPM 320-R Attachment A to the Division within five working days of identifying a person in need of Special Assistance. If the person has a Special Assistance need requiring immediate assistance, the notification form must be submitted immediately with a notation
indicating the urgency. The AdSS and their subcontracted providers should inform
the person of the notification and explain the benefits of having another person
involved who can provide Special Assistance, if able.

B. If the person is under a guardianship or one is in process, the documentation of such
must also be submitted to the Division. However, if the documentation is not
available at the time of submission of the AMPM 320-R Attachment A notification, the
form should be submitted within the required timeframes, followed by submittal of
the guardianship documentation.

C. The Division reviews the notification form to ensure that it contains sufficient
information detailing the criteria and responds to the AdSS and their subcontracted
providers by completing Part B of AMPM 320-R Attachment A within five working
days of receipt of the form. If the necessary information is not provided on the
form, the Division contacts the staff member submitting the notification for
clarification. If the notification is urgent, the Division will respond as soon as
possible, but generally within one working day of receipt of the notification.

D. The notification process is not complete until the Division completes Part B of the
form and sends it back to the AdSS and its subcontracted providers. The AdSS and
their subcontracted providers should follow up if no contact is made or if Part B is not
received within five working days.

E. The Division designates which agency/person will provide Special Assistance when
processing AMPM 320-R Attachment A. When the agency/person providing Special
Assistance changes, the Division processes an “updated Part B” to document the
change.

F. If the person or agency currently identified as providing Special Assistance is no
longer actively involved, the Division must notify Division of Healthcare Care
Advocacy & Advancement (DHCAA). If a DHCAA advocate is also assigned,
notification to the advocate is sufficient.

**Persons No Longer in Need of Special Assistance**

A. The AdSS or their subcontracted providers must notify the Division within 10 days of
an event or determination that a person in need of Special Assistance no longer
meets criteria by completing Part C of the original notification form (with Parts A and
B completed when first identified), noting:

1. The reason(s) why Special Assistance is no longer required
2. The effective date
3. The name, title, phone number and e-mail address of the staff person
   completing the form
4. The date the form is completed.
B. The following are instances that should prompt the AdSS or their subcontracted providers to submit a Part C:

1. The original basis for the person meeting Special Assistance criteria is no longer applicable and the person does not otherwise meet criteria.

   The AdSS or their subcontracted provider must first discuss the determination with the person or agency providing Special Assistance to obtain any relevant input, and this includes when a person is determined to no longer be a person with an SMI (proper notice and appeal rights must be provided and the period to appeal must have expired).

2. The person passes away.

3. The person’s episode of care is ended with the AdSS (on-Title XIX persons with an SMI will also be disenrolled) and the person is not transferred to another AdSS.

C. The AdSS or their subcontracted providers must first perform all required re-engagement efforts, which includes contacting the person providing Special Assistance, per AMPM Policy 1040, Outreach, Engagement, Re-engagement and Closure for Behavioral Health. Proper notice and appeal rights must be provided and the period to appeal must have expired prior to submission of Part C.

   Note: Submission of a Part C is not needed when a person transfers to another AdSS, as the Special Assistance designation follows the person.

D. Upon receipt of Part C of the AMPM 320-R Attachment A, the Division reviews content to confirm accuracy and completeness and returns it to the agency that submitted it, copying the AdSS or their subcontractors.

**Requirement of the Division, its AdSSs, Subcontractors to Help Ensure the Provision of Special Assistance**

A. The AdSS or their subcontracted providers must maintain open communication with the person (e.g., guardian, family member, friend, advocate) assigned to meet the person’s Special Assistance needs. Minimally, this involves providing timely notification to the person providing Special Assistance to ensure involvement in the following:

1. Behavioral Health ISP planning and review, which occurs in any instance when the person makes a decision regarding service options and/or denial/modification/termination of services (service options include not only a specific service but also potential changes to provider, site, and physician and case manager assignment).

2. Behavioral Health ISP development and updates, which must be in accordance with 320-O, Service Planning, Assessments, and Discharge Planning in this Policy Manual.

3. ITDP planning, which occurs any time a person is admitted to a psychiatric
inpatient facility and involvement throughout the stay and discharge.

4. Appeal process, which occurs in circumstances that may warrant the filing of an appeal, so all Notices Adverse Benefit Determination (NOA) or Notices of Decision (NOD) issued to the person/guardian must also be copied to the person designated to meet Special Assistance needs; and

5. Investigation or Grievance, which occurs when an investigation/grievance is filed and circumstances when initiating a request for an investigation/grievance may be warranted.

B. If such procedures are delayed in order to ensure the participation of the person providing Special Assistance, the AdSS, subcontracted providers must document the reason for the delay, in the clinical record or in the investigation, grievance or appeal file. If an emergency service is needed the AdSS, and/or their subcontracted providers must, ensure that the person receives the needed services in the interim and promptly notify the agency/person providing Special Assistance.

C. The AdSS must timely provide relevant details and a copy of the original AMPM 320-R Attachment A (both Parts A and B) to the receiving entity when a person in need of Special Assistance is

1. Admitted to an inpatient facility
2. Admitted to a residential treatment setting
3. Transferred to a different AdSS.

D. The AdSS must periodically review whether the person’s needs are being met by the person or agency designated to meet the person’s Special Assistance needs. If a concern arises, they should first address it with the person or agency providing Special Assistance. If the issue is not promptly resolved, they must take further action to address the issue, which may include contacting the Division for assistance.

**AdSS Reporting Requirements**

A. The AdSS must maintain a copy of completed AMPM 320-R Attachment A, Parts A, B and updated if any.

B. The AdSS must maintain a database on persons in need of Special Assistance to ensure compliance with this policy and the reporting requirements described in this section. This cannot be delegated to providers.

- The AdSS must, by the 10th calendar day of each month, provide the Division Compliance Unit with a comprehensive report listing of all persons in need of Special Assistance who are active as of the end of the previous month
- Any Part C notifications, during the previous month, that a person no longer needs Special Assistance
- Any persons transferred, to the AdSS during the previous month, who were
Special Assistance in the previous contractor or Tribal Regional Behavioral Health Authority (TRBHA)

- Any person in need of Special Assistance who was transferred from the AdSS to another AdSS.

The monthly reports must contain the following information:

1. CIS Number
2. Name
3. Date of Birth
4. Guardian (yes or no)
5. Current address
6. Current phone number
7. Type of residence
8. Whether currently at AzSH and unit name
9. AzSH Identification Number
10. Name of Provider
11. Name/location of Provider site
12. Name of Case Manager
13. Name of Clinical Supervisor
14. Title XIX (AHCCCS) enrollment status (yes or no)
15. Effective Date (date Part B was completed)
16. Person/relationship or agency meeting Special Assistance needs
17. Name, address and phone number of person meeting the Special Assistance needs
18. If applicable, the Date of Discharge from AzSH
19. If applicable, the Date of the Removal (when Part C of the notification was sent to the Division) or the event and event date that prompted the removal
20. If applicable, information on any updated Part B (indicating change in person meeting needs), and
21. If applicable, the Date of the transfer including the name of the receiving contractor.
C. By the 25th day of the month following the end of a quarter, the Division provides AdSS with a comprehensive report for the previous quarter.

D. The AdSS, in response to the Division’s quarterly report, must:
   1. Update the AdSS database with data updates contained in the quarterly report for persons assigned to an advocate.
   2. Submit an updated report to the Division by the 10th day of the next month. The report must identify any changes, in client information, for persons not assigned to an Advocate, that occurred during the previous quarter.

Examples include change in Title XIX enrollment, changes in the person’s residence, case management provider or case manager assignment, etc. The AdSS and the Division must work together to rectify any data discrepancies in a timely manner to ensure that the data maintained is accurate.

E. The Division, using data it maintains on all persons in need of Special Assistance, must provide a list of persons in each region to each Independent Oversight Committee (IOC) by the 25th calendar day of each month. The Division customarily provides a courtesy copy of the report.

F. By the 10th calendar day of each month, AdSS must provide the Division with a comprehensive report listing of persons in need of Special Assistance that were receiving services at AzSH during the previous month. The Division provides the final report to the DDD IOC and a copy to the AdSS by the 25th of the month.

G. AdSS must share Special Assistance data with its subcontracted providers that provide case management to persons determined to have an SMI and verify that a process exists at each case management provider to ensure this data is accessible by front-line provider staff (at a minimum quarterly). AdSS must also establish a process with such providers to obtain quarterly updates on persons currently identified as Special Assistance to support the AdSS quarterly data updates process with the Division.

Confidentiality Requirements

A. The AdSS and subcontracted providers must grant access to clinical records of persons in need of Special Assistance in accordance with federal and state confidentiality laws (see Division Medical Policy Manual 550).

B. DDD IOCs and their members must safeguard the monthly list that contains the names of those persons in need Special Assistance regarding any Protected Health Information (PHI). IOCs must inform AHCCCS annually in writing of how it will maintain the confidentiality of the Special Assistance lists. If IOCs request additional information that contains PHI that is not included in the monthly report.
**Other Procedures**

A. The AdSS must maintain a copy of the completed AMPM 320-R Attachment A, (Parts A and B and updated B, if any) in the person’s comprehensive clinical record. If a person was identified as no longer needing Special Assistance and a Part C of the notification form was completed, the AdSS and subcontracted providers must maintain a copy of the form in the comprehensive clinical record.

B. The AdSS must clearly document in the clinical record (i.e., on the assessment, ISP, ITDP, face sheet) and case management/client tracking system if a person is identified as in need of Special Assistance, the person assigned currently to provide Special Assistance, the relationship, contact information including phone number and mailing address.

C. The DDD IOCs must make regular visits to the residential environments of persons in need of Special Assistance to determine whether the services meet their needs and their satisfaction with the residential environment.

D. The AdSS must implement quality management measures to ensure the subcontracted providers implement the requirements of this policy. Audit tools and procedures must be shared with the Division prior to use to ensure they address:

1. Screening requirements
2. Documentation requirements
3. Provisions of Special Assistance requirements.

E. The AdSS must ensure that all applicable staff are trained regarding the requirements of Special Assistance (see Division Medical Policy Manual, Policy 1060).
320-U  PRE-PETITION SCREENING, COURT-ORDERED EVALUATION, AND COURT-ORDERED TREATMENT

EFFECTIVE DATE: October 1, 2019

This Policy establishes guidelines, as applicable, for the provision and coordination of behavioral health services regarding the pre-petition screening, court ordered evaluation, and court ordered treatment process.

Definitions

A. Court-Ordered Evaluation (COE) - A professional multidisciplinary analysis based on data describing the person’s identity, biography and medical, psychological and social conditions with all evaluation requirements defined in A.R.S. § 36-501.

B. Court-Ordered Treatment (COT) - In accordance with the A.A.C. R9-21-101 and A.R.S. § 36-533, an individual in Arizona can be ordered by the court to undergo mental health treatment if found to fit one of the following categories due to a mental disorder:
   1. A Danger to Self (DTS),
   2. A Danger to Others (DTO),
   3. Gravely Disabled (GD), or
   4. Persistently or Acutely Disabled (PAD).

C. Evaluation Agency - A health care agency licensed by the Arizona Department of Health Services (ADHS) that has been approved pursuant to A.R.S. Chapter 5 Title 36 providing those services required of such agency as delineated in the A.R.S. Chapter 5 Title 36 (A.R.S. § 36-501).

D. Mental Disorder - A substantial disorder of the individual’s emotional processes, thought, cognition, or memory as defined in A.R.S. §36-501.

E. Pre-Petition Screening - The review of each application requesting court ordered evaluation, including an investigation of facts alleged in such application, an interview with each applicant and an interview, if possible, with the proposed individual. The purpose of the interview with the proposed member is to assess the problem, explain the application, and, when indicated, attempt to persuade the proposed member to receive, on a voluntary basis, evaluation or other services.

F. Screening Agency - A health care agency licensed by ADHS and that provides those services required of such agency pursuant to A.R.S. Chapter 5 Title 36 (A.R.S. § 36-501).

G. Voluntary Evaluation - An inpatient or outpatient evaluation service that is provided after a determination that a person will voluntarily receive an evaluation and is unlikely to present a danger to self or others until the voluntary evaluation
Policy

This Policy outlines the processes and responsibilities applicable when it is necessary to initiate COE/COT proceedings detailed in A.R.S. §§ 36-501 et seq. This process is used to ensure the safety of an individual, or the safety of others when, due to an individual’s Mental Disorder, that individual is unable or unwilling to participate in treatment. AdSS responsibilities may vary for Pre-Petition Screening and COE based on contractual arrangements between the Division, AHCCCS, AdSS, and the counties. AdSS must ensure providers responsible for the COE/COT process adhere to requirements of this Policy.

When necessary, in accordance with A.A.C. R9-21-101 and A.R.S. § 36-520, any responsible person may submit an application, as specified in Attachment A (Application for Involuntary Evaluation), when another individual is alleged to be, as a result of a Mental Disorder:

- Danger to Self (DTS).
- Danger to Others (DTO).
- Persistently or Acutely Disabled (PAD), or
- Gravely Disabled (GD).

If the individual who is the subject of a court-ordered commitment proceeding is subject to the jurisdiction of a tribal nation, rather than the state, the laws of that tribal nation will govern the commitment process. Information about the tribal court process and the procedures under state law for recognizing and enforcing a tribal court order are found in this Policy.

Pre-Petition Screening includes an examination of the individual’s mental status and/or other relevant circumstances by a designated Screening Agency. Upon review of the application, examination of the individual and review of other pertinent information, a licensed Screening Agency’s medical director or designee will determine if the individual meets criteria for DTS, DTO, PAD, or GD as a result of a mental disorder.

If the pre-petition application screening indicates that the individual may be DTS, DTO, PAD, or GD, the Screening Agency will file an application, as specified in Attachment B (Application for Emergency Admission for Evaluation), for a COE. Based on the immediate safety of the individual or others, an emergency admission for evaluation may be necessary. The Screening Agency, upon receipt of the application must determine the need for continued evaluation and immediately act as prescribed, not to exceed 48 hours of the filing of the application excluding weekends and holidays as specified in A.R.S. § 36-520.

Based on the COE, the Evaluating Agency may petition for COT on behalf of the
individual. The subsequent hearing is the determination as to whether the individual will be court ordered to treatment as specified in A.R.S. § 36-539. COT may include a combination of inpatient and outpatient treatment. Inpatient treatment days are limited contingent on the individual’s designation as DTS, DTO, PAD, or GD. Individuals identified as:

- DTS may be ordered up to 90 inpatient days per year.
- DTO and PAD may be ordered up to 180 inpatient days per year, and
- GD may be ordered up to 365 inpatient days per year.

If the court orders a combination of inpatient and outpatient treatment, a mental health agency will be identified by the court to supervise the individual’s outpatient treatment. Before the court can order a mental health agency to supervise the individual’s outpatient treatment, the agency medical director must agree and accept responsibility by submitting a written treatment plan to the court.

At every stage of the Pre-Petition Screening, COE and COT process, an individual who manifests the capacity to give informed consent pursuant to A.R.S. § 36-518 will be provided an opportunity to change the status to voluntary. Under voluntary status, the individual will voluntarily receive an evaluation and is unlikely to present as DTO/DTS during the time pending the voluntary evaluation.

Entities responsible for COE must ensure the use of the following forms prescribed in 9 A.A.C. 21, Article 5 for individuals determined to have a Serious Mental Illness (SMI) and may also use these forms for all other populations:

- AMPM Policy 320-U, Attachment A, Application for Involuntary Evaluation
- AMPM Policy 320-U, Attachment B, Application for Emergency Admission for Evaluation
- AMPM Policy 320-U, Attachment C, Petition for Court Ordered Evaluation
- AMPM Policy 320-U, Attachment D, Petition for Court Ordered Treatment
- AMPM Policy 320-U, Attachment E, Affidavit, Addendum No. 1 and Addendum No. 2
- AMPM Policy 320-U, Attachment F - Flow Chart Recognition of Tribal Court Order Process

Although the AdSS may not be contracted for providing Pre-Petition Screening services, emergency/crisis petition filing, and COE services in all counties, the AdSS must provide policies and procedures for providers outlining these processes.

For FFS members not residing on a reservation, the FFS provider (mental health agency) must follow all legal authorities in the State and county of the FFS member’s place of
residence or the county in which treatment was ordered because of a behavioral health crisis occurring off tribal land.

FFS members residing on a reservation are subject to the tribe’s laws and tribal court jurisdiction. FFS providers (mental health agencies) must ensure clinical coordination with the appropriate entities including but not limited to American Indian tribes, TRBHAs, and tribal courts. Refer to this policy for more information regarding Tribal Court Orders.

A. Licensing Requirements

Behavioral health providers who are licensed by the ADHS/Division of Public Health Licensing as a COE or COT agency must adhere to ADHS licensing requirements.

B. Pre-Petition Screening

1. Unless otherwise indicated in an Intergovernmental Agreement (IGA) with a county, Arizona counties are responsible for managing, providing, and paying for Pre-Petition Screening and COEs and are required to coordinate provision of behavioral health services with the member’s AdSS or FFS program, responsible for the provision of behavioral health services. For additional information, visit the AHCCCS website, https://www.azahcccs.gov.

   During the Pre-Petition Screening, the designated Screening Agency must offer assistance, if needed, to the applicant in the preparation of the application for involuntary COE (see Attachment A, Application for Involuntary Evaluation). Any behavioral health provider that receives an application for COE (Attachment A, Application for Involuntary Evaluation) must immediately refer the application for Pre-Petition Screening and petitioning for COE to the AdSS-designated Pre-Petition Screening agency or county facility.

2. The AdSS must develop policies that outline its role and responsibility related to the treatment of individuals who are unable or unwilling to consent to treatment. The policy must conform to the processes provided in A.R.S. §§ 36-501 et seq, and at a minimum address:
   a. Involuntary evaluation,
   b. Petitioning process,
   c. COE/COT process, including tracking the status of Court orders,
   d. Execution of Court orders, and
   e. Judicial Review.

C. Responsibility for Providing Pre-Petition Screening
When the AdSS is responsible through an IGA with a county for Pre-Petition Screening and petitioning for COE, the AdSS must refer the applicant to a subcontracted Pre-Petition Screening Agency.

The Pre-Petition Screening Agency must follow these procedures:

1. Provide Pre-Petition Screening within 48 hours excluding weekends and holidays.

2. Prepare a report of opinions and conclusions. If Pre-Petition Screening was not possible, the Screening Agency must report reasons why the screening was not possible, including opinions and conclusions of staff members who attempted to conduct the Pre-Petition Screening.

3. Ensure the agency’s medical director or designee review of the report if the report indicates that there is no reasonable cause to support the allegations for COE by the applicant.

4. Prepare a petition for COE (Attachment C, Petition for Court Ordered Evaluation) and file the petition if the Screening Agency determines that due to a Mental Disorder, there is reasonable cause to believe that the individual meets the criteria set forth in § 36-521(D).

5. Ensure completion of Attachment B (Application for Emergency Admission for Evaluation), and take all reasonable steps to procure hospitalization on an emergency basis, if it determines that there is reasonable cause to believe that the individual, without immediate hospitalization, is likely to harm themselves or others.

6. Contact the county attorney prior to filing a petition if it alleges that an individual is DTO.

D. Emergent/Crisis Petition Filing Process for Contractors Contracted as Evaluating Agencies

When it is determined that there is reasonable cause to believe that the individual being screened is in a condition that without immediate hospitalization is likely to harm themselves or others, an emergent application must be filed. The petition must be filed at the appropriate agency as determined by the AdSS. Pursuant to A.R.S. § 36-501 et seq., when considering the emergent petition process, the following apply:

1. Only applications indicating DTS and/or DTO can be filed on an emergent basis.

2. The applicant must have knowledge of the behavior(s) displayed by the individual that is a danger to self or others consistent with requirements identified in A.R.S. § 36-524.

3. The applicant must complete Attachment B (Application for Emergency Admission for Evaluation).
4. The applicant and all witnesses identified in the application as direct observers of the dangerous behavior/s may be called to testify in court if the application results in a petition for COE.

5. Immediately Upon receipt of an Attachment B (Application for Emergency Admission for Evaluation) and all corroborating documentation necessary to successfully complete a determination, the admitting physician will determine if enough evidence exists for an emergency admission for evaluation. If there is enough evidence to support the emergency admission for evaluation, the appropriate facility is not currently operating at or above its allowable member capacity, and the individual does not require medical care, then, facility staff will immediately coordinate with local law enforcement for the detention of the individual and transportation to the appropriate facility.

6. If the individual requires a medical facility, or if appropriate placement cannot be arranged within the 48 hour timeframe identified above relating to Attachment B (Application for Emergency Admission for Evaluation), the Medical Director of the AdSS will be consulted to arrange for a review of the case.

7. Attachment B (Application for Emergency Admission for Evaluation) may be discussed by telephone with the facility admitting physician, the referring physician, and a peace officer to facilitate transportation of the individual to be evaluated.

8. An individual proposed for emergency admission for evaluation may be apprehended and transported to the facility under the authority of law enforcement using Attachment B (Application for Emergency Admission for Evaluation), in accordance with A.R.S. §§ 36-524(D) and 36-525(A), which outlines criteria for a peace officer to apprehend and transport an individual based upon either a telephonic or written application for emergency admission.

9. An emergency admission for evaluation begins at the time the individual is detained involuntarily by the admitting physician who determines if there is reasonable cause to believe that the individual, as a result of a Mental Disorder, is a DTS or DTO and that during the time necessary to complete pre-screening procedures the individual is likely, without immediate hospitalization, to suffer harm or cause harm to others.

10. During the emergency admission period of up to 23 hours the following occurs:
   a. The individual’s ability to consent to voluntary treatment is assessed,
   b. The individual must be offered and receive treatment to which the individual may consent; otherwise, the only treatment administered involuntarily will be for the safety of the individual or others, i.e.
seclusion/restraint or pharmacological restraint in accordance with A.R.S. § 36-513, and

C. When applicable, the psychiatrist will complete the Voluntary Evaluation within 24 hours of determination that the individual no longer requires an involuntary evaluation.

E. Court-Ordered Evaluation

1. If, after review of the petition for evaluation, the individual is reasonably believed to be DTS, DTO, PAD, GD as a result of a Mental Disorder, the court can issue an order directing the individual to submit to an evaluation at a designated time and place. The order must specify whether the evaluation will take place on an inpatient or an outpatient basis.

   a. The court may also order that, if the individual does not or cannot submit, the individual be taken into custody by a peace officer and delivered to an Evaluation Agency. For further requirements surrounding COEs on an inpatient basis, refer to A.R.S. § 36-529.

2. If the Pre-Petition Screening indicates that the individual may be DTS, DTO, PAD, or GD, the Screening Agency will file a petition for COE. When, through an IGA with a county, AdSS are contracted to provide COE, they must adhere to the following requirements when conducting COEs:

   a. An individual who is reasonably believed to be DTO, DTS, PAD, or GD as a result of a Mental Disorder must have a petition for COE prepared, signed and filed by the Medical Director of the agency or designee,

   b. An individual admitted to an Evaluation Agency must receive an evaluation as soon as possible, and receive care and treatment as required by their condition for the full period they are hospitalized,

   c. A clinical record must be kept for each individual that details all medical and psychiatric evaluations and all care and treatment received by the individual,

   d. An individual being evaluated on an inpatient basis must be released within 72 hours if further evaluation is not appropriate, unless the individual makes application for further care and treatment on a voluntary basis, or unless an application for COT has been filed, and

   e. On a daily basis at minimum, an evaluation must be conducted throughout the COE process for the purposes of determining if an individual desires to be switched to a voluntary status, or qualifies for discharge.

3. For information on individuals being released from COE, and on COE dispositions, refer to A.R.S. § 36-531.
4. For FFS members undergoing COE, the FFS provider (Evaluation Agency) is responsible for all aspects of care coordination with the appropriate entities, including but not limited to the Screening Agency conducting the Pre-Petition Screening if applicable, treatment agency if applicable, and AHCCCS DFSM.

F. Voluntary Evaluation

1. AdSS must require behavioral health providers that receive an application for Voluntary Evaluation to immediately refer the individual to a facility responsible for Voluntary Evaluations. The Voluntary Evaluation may be on an inpatient or outpatient basis. Voluntary Evaluation may be carried out only if chosen by the individual during the course of a Pre-Petition Screening after an application for evaluation has been made.

2. When an individual consents to Voluntary Evaluation, the evaluating agency must follow these procedures:
   a. Obtain the individual’s informed consent prior to the evaluation (Attachment G, Application for Voluntary Evaluation),
   b. Provide an evaluation at a scheduled time and place within five business days of the notice that the individual will voluntarily receive an evaluation, and
   c. For inpatient Voluntary Evaluations, complete evaluations in less than 72 hours of receiving notice that the individual will voluntarily receive an evaluation.

3. The AdSS must require behavioral health providers that conduct Voluntary Evaluation services to include the following in the comprehensive clinical record (see Division’s Medical Policy Manual Policy 940):
   a. A copy of the application for Voluntary Evaluation, Attachment G (Application for Voluntary Evaluation),
   b. A completed informed consent form (see Division Medical Policy Manual Policy 320-Q), and
   c. A written statement of the individual’s present medical condition.

G. Court-Ordered Treatment Following Civil Proceedings

Based on the COE, the evaluating agency may petition for COT. As specified in A.R.S. §§ 36-501 et seq, the AdSS must require behavioral health providers to follow these procedures:

1. Upon determination that a person is DTS, DTO, GD, or PAD, and if no alternatives to COT exist, the Medical Director of the agency that provided the COE must file a petition with the court for COT (see Attachment D, Petition for Court Ordered Treatment).
2. Any behavioral health provider filing a petition for COT must do so in consultation with the individual’s clinical team prior to filing the petition.

3. The petition must be accompanied by the affidavits of the two physicians who conducted the examinations during the evaluation period and by the affidavit of the applicant for the evaluation (Attachment E, Affidavit).

4. In cases of GD, a copy of the petition must be mailed to the public fiduciary in the county of the individual’s residence, or the county in which the individual was found before evaluation, and to any person nominated as guardian/legal representative. In addition, a copy of all petitions must be mailed to the superintendent of the Arizona State Hospital (AzSH).

5. For information regarding court options for treatment, release, discharge, annual reviews, or COT violations, refer to A.R.S. § 36-540 et seq. For requirements relating to Judicial Review, see A.R.S. §§ 36-546 and 36-546.01.
   a. For COT relating to DUI/Domestic Violence or other Criminal Offenses, refer to the Division Operations Manual Policy 423.

H. Individuals Who Are Title XIX/XXI Eligible and/or Determined to Have a Serious Mental Illness

When an individual referred for COT is Title XIX/XXI eligible and/or determined or suspected to have an SMI, AdSS must:

1. Conduct an evaluation to determine if the individual has an SMI in accordance with the Division Medical Policy Manual Policy 320-P, and conduct a behavioral health assessment to identify the individual’s service needs in conjunction with the individual’s clinical team, as specified in the Division Medical Policy Manual Policy 320-O.

2. Provide necessary COT and other covered behavioral health services in accordance with the individual’s needs, as determined by the individual’s clinical team, family members, other involved parties.

3. Perform, either directly or by contract, all treatment required by A.R.S. Title 36, Chapter 5, Article 5 and 9 A.A.C. 21, Article 5.

I. Court-Ordered Treatment for American Indian Tribal Members in Arizona

Arizona tribes are sovereign nations and tribal courts have jurisdiction over their members residing on reservation. Tribal court jurisdiction, however, does not extend to tribal members residing off the reservation or to state issued COE or COT due to a behavioral health crisis occurs off reservation.

Several Arizona tribes have adopted procedures in their tribal codes, which are similar to Arizona law for COE and COT, however, each tribe has its own laws that must be followed for the tribal court process.
Additional information on the history of the tribal court process, legal documents and forms, a diagram of payment structures, as well as contact information for the tribes, tribal liaisons, TRBHAs, and tribal court representatives can be found on the AHCCCS website under Tribal Court Procedures for Involuntary Commitment.

1. Tribal (COT) for American Indian tribal members in Arizona is initiated by the tribal behavioral health staff, the tribal prosecutor or other individuals as authorized under tribal laws. In accordance with tribal codes, tribal members who may be a danger to themselves or others and in need of treatment due to a Mental Disorder are evaluated and recommendations are provided to the tribal judge for a determination of whether tribal COT is necessary. Tribal court orders specify the type of treatment needed.

2. Since many tribes do not have treatment facilities on reservation to provide the treatment ordered by the tribal court, tribes may need to secure treatment off reservation for tribal members. To secure COT off reservation, the court order must be “recognized” or transferred to the jurisdiction of the state.

3. The process for establishing a tribal court order for treatment under the jurisdiction of the state is a process of recognition, or “enforcement” of the tribal court order (see A.R.S. § 12-136). Once this process occurs, the state recognized tribal court order is enforceable off reservation. The state recognition process is not a rehearing of the facts or findings of the tribal court. Treatment facilities must provide treatment as identified by the tribe and recognized by the state. Attachment F (Flow Chart Recognition of Tribal Court Order Process) is a flow chart demonstrating the communication between tribal and state entities in accordance with A.R.S. § 12-136.

4. AdSS and providers must comply with state recognized tribal court orders for Title XIX/XXI and Non-Title XIX individuals with an SMI determination. When tribal providers are also involved in the care and treatment of court ordered tribal members, AdSS and providers must involve tribal providers to ensure the coordination and continuity of care of the members for the duration of COT, and when members are transitioned to services on the reservation, as applicable. AdSS are encouraged to enter into agreements with tribes to address behavioral health needs and improve the coordination of care for tribal members.

5. The enforcement process must run concurrently with the tribal staff’s initiation of the tribal court ordered process in an effort to communicate and ensure clinical coordination with the appropriate AdSS. This clinical communication and coordination with the AdSS is necessary to assure continuity of care and to avoid delays in admission to an appropriate facility for treatment upon state/county court recognition of the tribal court order. The AzSH must be the last placement alternative considered and used in this process.
6. The Court must consider all available and appropriate alternatives for the treatment and care of the member. The Court must order the least restrictive treatment alternative available (A.R.S. § 36-540(B)). The AdSS is expected to partner with American Indian tribes, TRBHAs, and tribal courts in their geographic service areas to collaborate in finding appropriate treatment settings for American Indians in need of behavioral health services.

Due to the options American Indians have regarding their health care, including behavioral health services, AHCCCS eligible American Indians may be covered and/or coordinate behavioral health services through a TRBHA, AIHP, AdSS, Tribal ALTCS, IHS, or 638 tribal provider.

J. Reporting Requirements

In addition to any reporting requirements related to COE/COT otherwise identified in Contract, AdSS must submit Attachment H (COE deliverable) and Attachment I (COT deliverable) as specified in Contract.

For FFS members receiving COT, FFS providers responsible for the treatment must submit Attachment D, Petition for COT to the Division.

K. Reimbursement

1. Reimbursement for court ordered screening and evaluation services are the responsibility of the county pursuant to A.R.S. § 36-545. For additional information regarding behavioral health services refer to 9 A.A.C. 22.

2. Refer to the Division Operations Manual Policy 437 for clarification regarding financial responsibility for the provision of medically necessary behavioral health services rendered after the completion of a COE.

3. Title XIX/XXI funds must not be used to reimburse COE services.
   a. For any Title XIX/XXI enrolled member who has been admitted to an Evaluation Agency under a petition for COE, the evaluation period is deemed to end upon the filing of a petition for COT by the Evaluation Agency. County payment responsibility ends that day, and transfers to the AdSS, who must pay for all Title XIX/XXI medically necessary services thereafter, including services associated with the period of time between the filing of the Petition for COT, and the hearing set for the purposes of a judicial determination for the need for COT, and
   b. County responsibility for payment of medically necessary days also ends when the 72-hour COE period is exceeded, which does not include inpatient days falling on weekends or legal holidays or if the time of admission on the initial day of COE is after 5:00 pm.

4. For COEs that do not require an inpatient stay, any medically necessary physical health services provided to the individual must be the
responsibility of the AdSS of enrollment.
320-V BEHAVIORAL HEALTH RESIDENTIAL FACILITIES

EFFECTIVE DATE: October 1, 2019


This policy establishes requirements for the provision of care and services in a Behavioral Health Residential Facility (BHRF).

Definitions

A. Adult Recovery Team (ART) - A group of individuals who, following the nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, collaborate and are actively involved in an assessment of the member of the Division (member), service planning and service delivery.

At a minimum, the team consists of the member, his/her guardian (if applicable), advocates (if assigned), and a qualified behavioral health representative. The team may also include members of the enrolled member's family, physical health, behavioral health or social service providers, representatives or other agencies serving the member, professionals representing various areas of expertise related to the member's needs, designated representatives or other persons identified by the enrolled member.

B. Behavioral Health Condition - Mental, Behavioral, or Neurodevelopmental Disorder (F01-F99) diagnosis defined by International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM).

C. Behavioral Health Residential Facility - As specified in A.A.C. R9-10-101, a health care institution that provides treatment to a member experiencing a behavioral health issue that limits the member's ability to be independent or causes the member to require treatment to maintain or enhance independence.

D. Behavioral Health Paraprofessional - As specified in A.A.C. R9-10-101, an individual, who is not a behavioral health professional, who provides behavioral health services at, or for, a health care institution according to the health care institution’s policies and procedures, who:

1. If the behavioral health services were provided in a setting other than a licensed health care institution, would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; and

2. Is provided supervision by a behavioral health professional.

E. Behavioral Health Professional (BHP) –

1. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:

   a. Independently engage in the practice of behavioral health as defined
in A.R.S. § 32-3251, or

b. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. § 32-3251 under direct supervision as defined in A.A.C. R4-6-101,

2. A psychiatrist as defined in A.R.S. § 36-501
3. A psychologist as defined in A.R.S. § 32-2061
4. A physician
5. A behavior analyst as defined in A.R.S. §3 2-2091
6. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse
7. A registered nurse.

F. Behavioral Health Technician (BHT)

As specified in A.A.C. R9-10-101, an individual, who is not a behavioral health professional, who provides behavioral health services at, or for, a health care institution according to the health care institution's policies and procedures, who:

1. If the behavioral health services were provided in a setting other than a licensed health care institution, would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; and
2. Is provided with clinical oversight by a behavioral health professional.

G. BHREF Staff - Any employee of the BHREF agency including but not limited to Administrators, Behavioral Health Paraprofessionals, Behavioral Health Professionals (BHP) and Behavioral Health Technicians.

H. Child and Family Team (CFT) - A defined group of individuals that includes, at a minimum, the child and his or her family, a behavioral health representative, and any individuals important in the child’s life that are identified and invited by the child and family to participate. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches, and community resource providers, representatives from churches, synagogues, or mosques, agents from other service systems like (DCS) Department of Child Safety or the Division of Developmental Disabilities (DDD). The size, scope, and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore expand and Contract as necessary to be successful on behalf of the child.

I. Co-occurring - Coexistence of both a behavioral health and a substance use disorder.

J. Medication Assisted Treatment (MAT) - Use of medications in combination with
counseling and behavioral therapies for the treatment of substance use disorders.

K. Natural Support – Support provided by those individuals who know or are related to the member/family, but do not provide a paid service, such as a grandparent or neighbor who is connected to the member/family.

L. Peer/Recovery Support Service - Intentional partnerships, based on shared lived experiences, to provide social and personal support. This support is coupled with specific, skill-based training, coaching, or assistance to bring about social or personal change at the individual, family, or community level. These services can include a variety of individualized and personal goals, including living preferences, employment or educational goals and development of social networks and interests.

M. Peer/Recovery Support Specialist - Individual trained, credentialed, and qualified to provide peer/recovery support services within the AHCCCS Program.

N. Service Plan - A complete written description, of all covered health services and other informal supports, which includes individualized goals, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life.

O. Treatment Plan - Complete written description of all services to be provided by Behavioral Health Residential Facility. The Treatment Plan must be based on the intake assessments, outpatient Service Plan, and must include input from the CFT/ART. The Treatment Plan will be reviewed and updated at the BHRF with the member and CFT/ART at least once a month.

**Policy**

Care and services provided in a BHRF are based on a per diem rate (24-hour day), require prior and continued authorization, and do not include room and board.

AdSS must ensure appropriate notification is sent to the Primary Care Physician and Behavioral Health Provider/Agency/TRBHA upon intake to and discharge from the BHRF.

References to CFT/ARTs pertain to AdSS and not to Fee-For-Services (FFS) Programs or FFS populations. A CFT/ART is not required for FFS members to receive services.

A. Criteria for Admission

AdSS must have admission criteria for medical necessity that, at a minimum, include the below elements. AdSS must publish the criteria, subject to Division approval as specified in the Contract. BHRF providers providing services to FFS members must adhere to the below elements.

If a member has a diagnosed Behavioral Health Condition that reflects the symptoms and behaviors necessary for a request for residential treatment, the Behavioral Health Condition causing the significant functional and/or psychosocial impairment must be evidenced in the assessment by the following:

1. At least one area of significant risk of harm within the past three months as a
result of:

a. Suicidal/aggressive/self-harm/homicidal thoughts or behaviors without current plan or intent
b. Impulsivity with poor judgment/insight
c. Maladaptive physical or sexual behavior
d. Member’s inability to remain safe within his or her environment, despite environmental supports (i.e. Natural Supports)
e. Medication side effects due to toxicity or contraindications

2. At least one area of serious functional impairment as evidenced by:

a. Inability to complete developmentally appropriate self-care or self-regulation due to member’s Behavioral Health Condition(s)
b. Neglect or disruption of ability to attend to majority of basic needs, such as personal safety, hygiene, nutrition or medical care
c. Frequent inpatient psychiatric admissions or legal involvement due to lack of insight or judgment associated with psychotic or affective/mood symptoms or major psychiatric disorders
d. Inability to independently self-administer medically necessary psychotropic medications despite interventions such as education, regimen simplification, daily outpatient dispensing, and long-acting injectable medications
e. Impairments persisting in the absence of situational stressors that delay recovery from the presenting problem

3. A need for 24-hour behavioral health care and supervision to develop adequate and effective coping skills that will allow the member to live safely in the community

4. Anticipated stabilization cannot be achieved in a less restrictive setting

5. Evidence that appropriate treatment in a less restrictive environment has not been successful or is not available, therefore warranting a higher level of care

6. Member agrees to, and participates in, treatment. In the case of minors, family/guardian/designated representative also agrees to and participates as part of the treatment team.

B. Expected Treatment Outcomes

1. Treatment outcomes must align with all of the following:

a. The Arizona Vision-12 Principles for Children’s Behavioral Health
Service Delivery as directed in AMPM Policy 430

b. The 9 Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems as outlined in Contract

c. The member’s individualized basic physical, behavioral, and developmentally appropriate needs.

2. Treatment goals must be:

a. Specific to the member’s Behavioral Health Condition(s)

b. Measurable and achievable

c. Unable to be met in a less restrictive environment

d. Based on the member’s unique needs and tailored to the member and the family’s/guardian’s/designated representative’s choices where possible

e. Supportive of the member’s improved or sustained functioning and integration into the community.

C. Exclusionary Criteria

Admission to a BHRF must not be used as a substitute for the following:

1. An alternative to detention or incarceration

2. A means to ensure community safety in circumstances where a member is exhibiting primarily conduct disordered behavior without the presence of risk or functional impairment

3. A means of providing safe housing, shelter, supervision, or permanency placement

4. A behavioral health intervention when other less restrictive alternatives are available and meet the member’s treatment needs; including situations when the member/guardian/designated representative are unwilling to participate in the less restrictive alternative, or

5. An intervention for runaway behaviors unrelated to a Behavioral Health Condition.

D. Criteria for Continued Stay

AdSS must have medical necessity criteria for continued stay that, at a minimum, include the below elements. AdSS must publish those criteria, subject to Division approval as specified in Contract. BHRF providers providing services to FFS members must adhere to the below elements.
During Treatment Plan review BHRF staff, and as applicable the CFT/ART, must assess continued stay and update the Treatment Plan. Progress towards the treatment goals and continued display of risk and functional impairment must also be assessed.

Treatment interventions, frequency, crisis/safety planning, and targeted discharge must be adjusted accordingly to support the need for continued stay. The following criteria must be considered when determining continued stay:

1. The member continues to demonstrate significant risk of harm and/or functional impairment as a result of a Behavioral Health Condition.
2. Providers and supports are not available to meet current behavioral and physical health needs at a less restrictive lower level of care.

E. Discharge Readiness

AdSS must have medical necessity criteria for discharge that, at a minimum, include the below elements. AdSS must publish that criteria, subject to Division approval as specified in Contract. BHRF providers providing services to FFS members must adhere to the minimum discharge elements below.

Discharge readiness must be assessed by the BHRF staff and as applicable by the CFT/ART during each Treatment Plan review and update. The following criteria must be considered when determining discharge readiness:

1. Symptom or behavior relief is reduced as evidenced by completion of Treatment Plan goals.
2. Functional capacity is improved; essential functions such as eating or hydrating necessary to sustain life has significantly improved or is able to be cared for in a less restrictive level of care.
3. Member can participate in needed monitoring or a caregiver is available to provide monitoring in a less restrictive level of care.
4. Providers and supports are available to meet current behavioral and physical health needs at a less restrictive level of care.

F. Admission, Assessment, and Treatment Plan

AdSS must have a policy to ensure the admission, assessment, and treatment planning process is completed consistently among all providers in accordance with A.A.C. R9-10-707 and 708 and Contract requirements. BHRF Providers rendering services to Fee-For-Service members must follow the below outlined admission, assessment, and treatment planning requirements.

1. Except as provided in subsection R9-10-707(A)(9), a behavioral health assessment for a member is completed before treatment is initiated and within 48 hours of admission.
2. The CFT/ART/TRBHA, as applicable, is included in the development of the Treatment Plan within 48 hours of admission for members enrolled with the AdSS.

3. All BHRFs serving TRBHA members must coordinate care with the TRBHAs throughout the admission, assessment, treatment, and discharge process.

4. The Treatment Plan connects back to the member’s comprehensive Service Plan for members enrolled with the AdSS.

5. A comprehensive discharge plan is created during the development of the initial Treatment Plan and is reviewed and/or updated at each review thereafter. The discharge plan must document the following:
   a. Clinical status for discharge
   b. Member/guardian/designated representative and, CFT/ART/TRBHA as applicable, understands follow-up treatment, crisis and safety plan, and
   c. Coordination of care and transition planning are in process (e.g. reconciliation of medications, applications for lower level of care submitted, follow-up appointments made).

6. The BHRF staff and the CFT/ART as applicable meet to review and modify the Treatment Plan at least once a month.

7. A Treatment Plan may be completed by a BHP, or by a BHT with oversight and signature by a BHP within 24 hours.

8. The provider has a system to document and report on timeliness of BHP signature/review when the Treatment Plan is completed by a BHT.

9. The provider has a process to actively engage family/guardians/designated representative in the treatment planning process as appropriate.

10. The provider’s clinical practices, as applicable to services offered and population served, must demonstrate adherence to best practices for treating the following specialized service needs, which include but are not limited to:
    a. Cognitive/intellectual disability
    b. Cognitive disability with comorbid Behavioral Health Condition(s)
    c. Older adults, and co-occurring disorders (substance use and Behavioral Health Condition(s), or
    d. Comorbid physical and Behavioral Health Condition(s).

11. Services deemed medically necessary through the assessment and/or CFT/ART/TRBHA as applicable, which are not offered at the BHRF, must be documented in the Service Plan and documentation must include a description of the need, identified goals and identified provider who will be meeting the
need. The following services must be made available and provided by the BHRF and cannot be billed separately unless otherwise noted below:

a. Counseling and Therapy (group or individual)

Group Behavioral Health Counseling and Therapy may not be billed on the same day as BHRF services unless specialized group behavioral health counseling and therapy have been identified in the Service Plan as a specific member need that cannot otherwise be met as required within the BHRF setting.

b. Skills Training and Development

i. Independent Living Skills (e.g., self-care, household management, budgeting, avoidance of exploitation/safety education and awareness)

ii. Community Reintegration Skill building (e.g., use of public transportation system, understanding community resources and how to use them)

iii. Social Communication Skills (e.g., conflict and anger management, same/opposite-sex friendships, development of social support networks, recreation)

c. Behavioral Health Prevention/Promotion Education and Medication Training and Support Services, including but not limited to:

i. Symptom management (e.g., including identification of early warning signs and crisis planning/use of crisis plan)

ii. Health and wellness education (e.g., benefits of routine medical check-ups, preventive care, communication with the PCP and other health practitioners)

iii. Medication education and self-administration skills

iv. Relapse prevention

v. Psychoeducation Services and Ongoing Support to Maintain Employment Work/Vocational skills, educational needs assessment and skill building

vi. Treatment for Substance Use Disorder (e.g., substance use counseling, groups)

vii. Personal Care Services (see additional licensing requirements in A.A.C. R9-10-702, R9-10-715, R9-10-814).

G. BHRF and Medication Assisted Treatment
AdSS and BHRF providers must have policies and procedures to ensure members on Medication Assisted Treatment (MAT) are not excluded from admission and are able to receive MAT to ensure compliance with Arizona Opioid Epidemic Act SB 1001, Laws 2018. First Special Session.

H. BHRF with Personal Care Services

BHRFs licensed to provide Personal Care Services must offer services in accordance with A.A.C R9-10-702 and A.A.C R9-10-715. AdSS and BHRF providers must ensure that all identified needs can be met in accordance with R9-10-814 (A)(C)(D) and (E).

The following are examples of services that may be provided:

A. Blood sugar monitoring, Accu-Check diabetic care
B. Administration of oxygen
C. Application and care of orthotic devices
D. Application and care of prosthetic devices
E. Application of bandages and medical supports, including high elastic stockings
F. ACE wraps, arm and leg braces, etc.
G. Application of topical medications
H. Assistance with ambulation
I. Assistance with correct use of cane/crutches
J. Bed baths
K. Care of hearing aids
L. Radial pulse monitoring
M. Respiration monitoring
N. Denture care and brushing teeth
O. Dressing member
P. Supervising self-feeding of members with swallowing deficiencies
Q. Hair care, including shampooing
R. Incontinence support, including assistance with bed pans/bedside commodes/ bathroom supports
S. Measuring and recording blood pressure
T. Non-sterile dressing change and wound care

U. Passive range of motion exercise

V. Use of pad lifts

W. Shaving

X. Shower assistance using shower chair

Y. Skin maintenance to prevent and treat bruises, injuries, pressure sores. Members with stage 3 or 4 pressure sore is not to be admitted to BHRF (A.A.C.R9-10-715(3)), and infections

Z. Use of chair lifts

AA. Skin and foot care

BB. Measuring and giving insulin, glucagon injection

CC. G-tube care

DD. Ostomy and surrounding skin care

EE. Catheter care
CHAPTER DELIVERABLES

Deliverables specific to individual Policies are identified in those individual Policies.

Deliverables related to this Chapter as a whole include:

1. Pregnancy Termination
2. Quality Management/Performance Improvement (QM/PI) Program Annual Plan
3. Sterilization Reporting
4. Stillbirth Supplement Request
5. AHCCCS Certificate of Necessity for Pregnancy Termination & AHCCCS Verification of Diagnosis by Contractor for Pregnancy Termination requests
6. Dental Plan and Evaluation
7. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and Adult Monitoring Report
8. EPSDT Plan and Evaluation
9. Maternity Care Plan and Evaluation
10. Number of Pregnant Women who are HIV/AIDS Positive.
410 - MATERNITY CARE SERVICES

EFFECTIVE DATE: October 1, 2019

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; Section F3, Contractor Chart of Deliverables

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The Division contracts with Administrative Services Subcontractors (AdSS) and delegates the responsibility of implementation of this policy. All maternity services covered by the Division are provided by the AdSS.

Definitions

A. **Certified Nurse Midwife (CFM)** - An individual certified by the American College of Nursing Midwives (ACNM) on the basis of a national certification examination and licensed to practice in Arizona by the State Board of Nursing. CNMs practice independent management of care for pregnant women and newborns, providing antepartum, intrapartum, postpartum, gynecological, and newborn care, within a health care system that provides for medical consultation, collaborative management, or referral.

B. **Free Standing Birthing Centers** - Out-of-hospital, outpatient obstetrical facilities, licensed by the ADHS and certified by the Commission for the Accreditation of Free Standing Birthing Centers. These facilities are staffed by registered nurses to provide assistance with labor and delivery services. They are equipped to manage uncomplicated, low-risk labor and delivery. These facilities shall be affiliated with, and in close proximity to, an acute care hospital for the management of complications, should they arise.

C. **High-Risk Pregnancy** - Refers to a pregnancy in which the mother, fetus, or newborn is, or is anticipated to be, at increased risk for morbidity or mortality before or after delivery. High-risk is determined through the use of the Medical Insurance Company of Arizona (MICA) or American Congress of Obstetricians and Gynecologists (ACOG) standardized medical risk assessment tools.

D. **Licensed Midwife** - An individual licensed by the Arizona Department of Health Services (ADHS) to provide maternity care pursuant to A.R.S. Title 36, Chapter 6, Article 7 and A.A.C. Title 9, Chapter 16 (This provider type does not include certified nurse midwives licensed by the Board of Nursing as a nurse practitioner in midwifery or physician assistants licensed by the Arizona Medical Board).

E. **Maternity Care** - Includes identification of pregnancy, prenatal care, labor/delivery services, and postpartum care.

F. **Maternity Care Coordination** - Consists of the following maternity care related activities: determining the member's medical or social needs through a risk assessment evaluation; developing a plan of care designed to address those needs; coordinating referrals of the member to appropriate service providers and community
resources; monitoring referrals to ensure the services are received; and revising the plan of care, as appropriate.

G. **Perinatal Services** - Medical services for the treatment and management of obstetrical patients and neonates (A.A.C. R9-10-201).

H. **Practitioner** - Refers to certified nurse practitioners in midwifery, physician's assistants, and other nurse practitioners. Physician's assistants and nurse practitioners are defined in A.R.S. Title 32, Chapters 25 and 15 respectively.

I. **Postpartum** - For the purposes of this Policy, postpartum is defined as the period beginning the day of parturition and ends the last day of the month in which the 57th day following parturition occurs.

J. **Postpartum Care** - The period beginning the day of parturition and ends the last day of the month in which the 57th day following parturition occurs.

K. **Preconception Counseling** - The provision of assistance and guidance 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. 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. The purpose of preconception counseling is to ensure that a woman is healthy prior to pregnancy.

Preconception counseling is considered included in the well-woman preventative care visit and does not include genetic testing.

L. **Prenatal care** - Prenatal care is the health care provided during pregnancy and is composed of three major components:

1. Early and continuous risk assessment
2. Health education and promotion
3. Medical monitoring, intervention, and follow-up.

**Policy**

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 AdSS 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 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
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. Semiannually, each 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 Section F3, Contractor Chart of 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. Inclusion of 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 60 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 forms to the Division 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 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 as required on the Contract, Section F3, Contractor Chart of Deliverables 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 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 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
2. Licensed midwives, if included in the AdSS 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/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 referred for support services to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), as well as other community-based resources, in order to support healthy pregnancy outcomes. 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.
g. Postpartum services must be provided to members within 60 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 must be shared with the AdSS providers, as appropriate. Special policy and procedural guidelines include, but are not limited to:

1. Circumcision of Newborn Male Infants

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 up to 48 hours of inpatient hospital care for a vaginal delivery without complications and up to 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. 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 close 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. For members who meet medical criteria specified in this policy, 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. Only members, for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated, may be scheduled to deliver in the member’s home. 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 close 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 close 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 provider network.

b. Licensed midwife services may be provided only to members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated. 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. Members determined to have a high-risk 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 close 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, to enroll the newborn with AHCCCS.

7. Supplemental Stillbirth Payment
Stillbirth refers to those infants, either pre-term or term, delivered in the third trimester of a documented pregnancy, who were deemed a fetal demise. 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
b. Attained a gestational age of at least 24 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 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.

EPSDT 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 85012

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. Termination Criteria
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 per 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 conditions for the pregnant member by:
   - Creating a serious physical or behavioral health conditions 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,
   - Preventing the pregnant member from obtaining treatment for a health problem.

b. 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 (AMPM Attachment 410-C) and supporting clinical documentation to DDD and the AdSS.

The certificate must be submitted to the Division’s and AdSS 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.

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 abortion 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: Contractors 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). 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 form, 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

iv. A copy of documentation confirming pregnancy termination occurred, and

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

f. Prior Authorization

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. AHCCCS Certificate of Necessity for Pregnancy Termination (AMPM Attachment 410-C)

ii. AHCCCS 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.


420 FAMILY PLANNING

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 36.2904(L), 42 CFR 50.203 and 204, AMPM Attachment 420-B

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

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 under “Covered Services.” 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.

Covered 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 Hysterosalpingogram 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 Mifepristone (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 Mifepristone (Mifeprex or RU-486)], and
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 use 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.

The AdSS will provide information about covered family planning services. Member notification of these covered services must meet the following minimum requirements:
A. In accordance with A.R.S. § 36-2904(L), the AdSS 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.

B. 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.

C. Notification must 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.

D. Notification must include all of the covered family planning services and instructions to members regarding how to access these services.

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

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

G. The AdSS must monitor compliance to ensure the maternity care providers verbally notify members of the availability of family planning services during office visits.

H. 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 must 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 communicated 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, or
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, DIAGNOSTIC AND TREATMENT SERVICES

REVISION DATE: 10/1/2019
REFERENCES: 42 CFR 441.58, 42 CFR 441.56(B)(1), 441.50; 42 U.S.C. 1396d(a) and (r), 1396a (a) (43); A.R.S. § 36-135; A.A.C. R9-13-201 et seq, A.A.C. R9-4-302, A.A.C. R9-22-201 et seq; Division Medical Policy 310-P; AMPM Exhibits 400-1, 400-2B, 400-3, 430-1, 430-2, 430-3, 430-4, and 431-1; AMPM Appendices A, B, E, and F; AMPM Chapter 800

DELIVERABLES: Children’s Provider Case Manager Caseload Inventories and Ratios

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral/mental health conditions for members eligible for ALTCS and Targeted Support Coordination under 21 years of age. The purpose of EPSDT is to ensure the availability and accessibility of health care resources, and to assist members in effectively using these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health conditions for members under 21 years of age.

EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary, mandatory, and optional services listed in federal law 42 U.S.C. 1396d (a) to correct or ameliorate defects and physical and behavioral/mental illnesses and conditions identified in an EPSDT screening, whether or not the services are covered under the AHCCCS State Plan. All members age out of Oral Health & EPSDT services at age 21. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

A well child visit is synonymous with an EPSDT visit. EPSDT services include all screenings and services described in this Policy and as referenced in AHCCCS EPSDT Periodicity Schedule (AMPM Exhibit 430-1) and AHCCCS Dental Periodicity Schedule (AMPM Exhibit 431-1) located in the AHCCCS Medical Policy Manual.

The Division has adopted Appendix B, EPSDT Standards and Tracking Forms in the AHCCCS Medical Policy Manual, which are to be used by providers to document all age-specific, required information related to EPSDT screenings and visits.

Providers must use the EPSDT Tracking Forms referenced above or electronic equivalent that includes all components found in the hard copy form, at every EPSDT visit.

The Medicaid Act defines EPSDT services to include screening services, vision services, dental services, hearing services and “such other necessary health care, diagnostic services, treatment and other measures described in 42 U.S.C. 1396d (a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the (AHCCCS) State Plan.” This means that EPSDT covered services include services that correct or ameliorate physical and mental defects, conditions, and illnesses discovered by the screening process when those services fall within one of the optional and mandatory categories of “Medical Assistance”, as defined in the Medicaid Act. Services covered under EPSDT include all 29 categories of services in the Federal Law, even when they are not listed as covered services in the...
AHCCCS State Plan, statutes, rules, or policies, as long as the services are medically necessary and cost effective.

EPSDT includes, but is not limited to, coverage of:

A. Inpatient and outpatient hospital services
B. Laboratory and x-ray services
C. Physician and nurse practitioner services
D. Medications and medical supplies
E. Dental services
F. Therapy services
G. Behavioral health services
H. Orthotics and prosthetic devices
I. Eyeglasses
J. Transportation
K. Family planning services
L. Diagnostic, screening, preventive, and rehabilitative services.

EPSDT services do not include services that are experimental, that are solely for cosmetic purposes, or that are not cost effective when compared to other interventions or treatments.

EPSDT screening services are provided in compliance with the periodicity requirements of 42 CFR 441.58. The Administrative Services Subcontractor (AdSS) must ensure members receive required health screenings in compliance with the AHCCCS EPSDT Periodicity Schedule and the AHCCCS Dental Periodicity Schedule, which are intended to meet reasonable and prevailing standards of medical and dental practice and specify screening services at each stage of the child's life; see AHCCCS EPSDT Periodicity Schedule (AMPM Exhibit 430-1) and AHCCCS Dental Periodicity Schedule (AMPM Exhibit 431-1). The service intervals are minimum requirements, and any services determined by a Primary Care Provider (PCP) to be medically necessary must be provided, regardless of the interval. The requirements and reporting forms for an EPSDT screening service are described in this Policy. EPSDT focuses on continuum of care by: assessing health needs, providing preventive screening, initiating needed referrals, and completing recommended medical treatment and appropriate follow-up.

A. EPSDT Definitions
Early - in the case of a child already enrolled with an AdSS or AHCCCS Contractor, as early as possible in the child's life, or in other cases, as soon after the member's eligibility for services has been established.

Periodic - at intervals established by AHCCCS for screening to assure that a condition, illness, or injury is not incipient or present.

Screening - regularly scheduled examinations and evaluations of the general physical and behavioral health, growth, development, and nutritional status of infants, children, and adolescents, and the identification of those in need of more definitive evaluation. For the purpose of the EPSDT program, screening and diagnosis are not synonymous.

Diagnostic - determination of the nature or cause of a condition, illness, or injury through the combined use of health history, physical, developmental, and psychological examination, laboratory tests, and X-rays, when appropriate.

Treatment - any of the 29 mandatory or optional services described in 42 U.S.C. 1396d(a), even if the service is not covered under the (AHCCCS) State Plan, when necessary to correct or ameliorate defects and physical and mental illnesses and conditions detected by screening or diagnostic procedures.

B. Covered Services During an EPSDT Visit

Comprehensive periodic screenings must be performed by a clinician, according to the timeframes identified in the AHCCCS EPSDT Periodicity Schedule and the AHCCCS Dental Periodicity Schedule, and inter-periodic screenings, as appropriate, for each member. All covered services during an EPSDT visit are provided by the AdSS.

The AdSS must:

1. Implement processes to ensure age-appropriate screening and care coordination when member needs are identified.

2. Ensure providers use the-approved standard developmental screening tools and complete training in the use of these tools, as indicated by the American Academy of Pediatrics.

3. Monitor providers and implement interventions for non-compliance.

4. Ensure that the Bloodspot Newborn Screening Panel and hearing tests are conducted, including initial and secondary screenings, in accordance with Arizona Administrative Code (A.A.C.) R9-13-201 et seq.

The AHCCCS EPSDT Periodicity Schedule is based on recommendations by the Arizona Medical Association and is closely aligned with the guidelines of the American Academy of Pediatrics. The service intervals are minimum requirements. Any services determined by a PCP to be medically necessary must be provided, regardless of the interval.
EPSDT visits are all-inclusive visits. The payment for the EPSDT visit is intended to cover all elements outlined in the AHCCCS EPSDT Periodicity Schedule. Exceptions to payments are noted in each of the paragraphs below. Only services specifically identified below as a separately billable service may be billed separately or in addition to the EPSDT visit.

EPSDT visits must include:

1. A comprehensive health and developmental history, including growth and development screening [42 CFR 441.56(B)(1)] that includes physical, nutritional, and behavioral health assessments
   Refer to the Centers for Disease Control and Prevention website for Body Mass Index (BMI) and growth chart resources.

2. Nutritional Assessment provided by a PCP
   Nutritional assessments are conducted to assist EPSDT members whose health status may improve with nutritional intervention. Payment for the assessment of nutritional status provided by the member's PCP is part of the EPSDT screening specified in the AHCCCS EPSDT Periodicity Schedule, and on an inter-periodic basis as determined necessary by the member’s PCP. Payment for nutritional assessments are included in the EPSDT visit and are not a separately billable service.

3. Behavioral Health Screening and Services provided by a PCP
   The Division covers behavioral health services for members eligible for EPSDT. EPSDT behavioral health services include the services listed in 42 U.S.C. 1396d(a) necessary to correct or ameliorate mental illnesses and conditions discovered by the screening services, whether or not the services are covered under the (AHCCCS) State Plan. PCPs may treat Attention Deficit Hyperactivity Disorder (ADHD), depression and anxiety.

   All other behavioral health conditions must be referred to the entity for which the member is assigned for behavioral health services. American Indian members may receive behavioral health services through an Indian Health Service or Tribal operated 638 facility, regardless of AdSS enrollment. PCPs that prescribe medications to treat ADHD, depression, or anxiety disorders must complete an annual assessment of the member’s behavioral health condition and treatment plan. Payment for behavioral health screenings and assessments are part of an EPSDT visit and not separately billable services.

Note: CPT code 96101 PSYCHOLOGICAL TESTING (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology) is not a separately billable service. The code may be billed on the claim to indicate the service was performed, but payment will be included in the fee paid for the EPSDT visit.
4. Developmental Screening Tools used by a PCP

AHCCCS-approved developmental screening tools should be used for developmental screening by all participating PCPs who care for EPSDT-age members. PCPs must be trained in the use and scoring of the developmental screening tools, as indicated by the American Academy of Pediatrics. A list of available training resources may be found in the Arizona Department of Health Services website at www.azdhs.gov/clinicians/training-opportunities/developmental/index.php. The developmental screening should be completed for EPSDT members from birth through three years of age during the nine-month, 18-month, and 24-month EPSDT visits. A copy of the screening tool must be kept in the medical record. Use of AHCCCS approved developmental screening tools may be billed separately using CPT-4 code 96110 (Developmental screening, with interpretation and report, per standardized instrumentation) for the nine-month, 18-month and-24 month visit when the developmental screening tool is used. A developmental screening CPT code (with EP modifier) must be listed in addition to the preventive medicine CPT codes. Other CPT-4 codes, such as 96111 – Developmental Testing (includes assessment of motor, language, social, adaptive) are not considered screening tools and are not separately billable. To receive the developmental screening tool payment, the modifier EP must be added to the 96110. For claims to be eligible for payment of code 96110; the provider must have satisfied the training requirements, the claim must be a 9, 18, or 24-month EPSDT visit, and an AHCCCS approved developmental screening tool must have been completed.

Approved developmental screening tools include:

a. The Parent’s Evaluation of Developmental Status (PEDS) tool which may be obtained from www.pedstest.com or www.forepath.org

b. Ages and Stages Questionnaire (ASQ) tool, which may be obtained from www.agesandstages.com

c. The Modified Checklist for Autism in Toddlers (MCHAT) may be used only as a screening tool by a PCP, for members 16-30 months of age, to screen for autism when medically indicated. Copies of the completed tools must be retained in the medical record.

5. A comprehensive unclothed physical examination

6. Appropriate immunizations according to age and health history

(administration of the immunizations may be billed in addition to the EPSDT visit using the CPT-4 code appropriate for the immunization with an SL modifier)

Combination vaccines are paid as one vaccine. Providers must be registered as Vaccines for Children (VFC) providers and VFC vaccines must be used.
7. Laboratory tests, including blood lead screening assessment and blood lead testing appropriate to age and risk, anemia testing, and diagnostic testing for sickle cell trait (if a child has not been previously tested with sickle cell preparation or a hemoglobin solubility test)

EPSDT covers blood lead screening. Required blood lead screening for children under six year of age is based on the child’s risk as determined by either the member’s residential zip code or presence of other known risk-factors, as specified in the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning. For more information refer to Blood Lead Screening section in this policy for more information.

Payment for laboratory services that are not separately billable and part of the payment made for the EPSDT visit include but are not limited to: CPT Codes 99000, 36415, 36416, 36400, 36406, and 36410. In addition, payment for all laboratory services must be in accordance with limitations or exclusions specified in contract.

8. Health education, counseling, and chronic disease self-management

These are not separately billable services, and they are part of the EPSDT visit payment.

9. Appropriate oral health screening, intended to identify oral pathology, including tooth decay and/or oral lesions, and the application of fluoride varnish conducted by a physician, physician’s assistant, or nurse practitioner

Application of fluoride varnish may be billed separately from the EPSDT visit, using CPT Code 99188. Fluoride varnish is limited in a PCP’s office to once every six months, during an EPSDT visit for children who have reached six months of age with at least one tooth erupted, with recurrent applications up to two years of age.

10. Appropriate vision, hearing, and speech screenings

These screenings are covered during an EPSDT visit.

EPSDT covers eye examinations as appropriate to age according to the AHCCCS EPSDT Periodicity Schedule and as medically necessary using standardized visual tools. Payment for vision and hearing exams, (including, but not limited to CPT codes 92015, 92081, 92285, 92551, 92552, 92553, 92567, 92568, 92285, 92286, 92587, 92588, 95930, and 99173) or any other procedure that may be interpreted as fulfilling the vision and hearing requirements provided in a PCP’s office during an EPSDT visit, are part of the EPSDT visit and are not a separately billable services.

Ocular photo screening with interpretation and report, bilateral (CPT code 99177) is covered for children age three to five as part of the EPSDT visit due
to challenges with a child’s ability to cooperate with traditional vision screening techniques. Ocular photo screening is limited to a lifetime coverage limit of one. This procedure, although completed during the EPSDT visit, is a separately billable service.

Note: Automated visual screening, described by CPT code 99177, is not recommended for or covered by the Division when used to determine visual acuity for purposes of prescribing glasses or other corrective devices.

Vision CPT codes with the EP modifier must be listed on the claim form in addition to the preventive medicine CPT codes for visit screening assessment. With the exception of CPT code 99177, no additional reimbursement is allowed for these codes.

Hearing CPT codes with the EP modifier must be listed on the claim form, in addition to the preventive medicine CPT codes, for a periodic hearing screening assessment. With the exception of CPT code 99177, no additional reimbursement is allowed for these codes.

The AdSS must ensure:

a. Each hospital or birthing center screens all newborns using a physiological hearing screening method prior to initial hospital discharge.

b. Each hospital or birthing center provides outpatient re-screening for babies who were missed or are referred from the initial screening. Outpatient re-screening must be scheduled at the time of the initial discharge and completed between two and six weeks of age.

c. When there is an indication that a newborn or infant may have a hearing loss or congenital disorder, the family must be referred to the PCP for appropriate assessment, care coordination and referral(s).

d. All infants with confirmed hearing loss receive services before turning six months of age.

11. Tuberculin skin testing, as appropriate to age and risk

Children at increased risk of tuberculosis (TB) include those who have contact with persons who have been:

a. Confirmed or suspected as having TB

b. In jail or prison during the last five years

c. Living in a household with an HIV-infected person or the child is infected with HIV
d. Traveling/emigrating from, or having significant contact with persons indigenous to, endemic countries.

C. EPSDT Service Standards

EPSDT services must be provided according to community standards of practice and the AHCCCS EPSDT and Dental Periodicity Schedules. The AHCCCS EPSDT Tracking Forms must be used to document services provided and be in compliance with Division standards. The tracking forms must be signed by the clinician who performs the screening. The AdSS must monitor PCPs’ use of and submission of EPSDT Tracking Forms, whether hard copy or electronic, to the AdSS Maternal and Child Health Unit.

All EPSDT services are provided by the AdSS. EPSDT providers must adhere to the following specific standards and requirements:

1. **Immunizations** - EPSDT covers all child and adolescent immunizations, as specified in the Centers for Disease Control and Prevention (CDC) recommended childhood immunization schedules. All appropriate immunizations must be provided to establish, and maintain, up-to-date immunization status for each EPSDT age member. (Refer to the CDC website for current immunization schedules.)

The Division covers the human papilloma virus (HPV) vaccine for female and male EPSDT members age 11 to 21 years of age. The Division will cover members nine and 10 years of age, if the member is deemed to be in a high-risk situation. For adult immunizations, refer to Chapter 310-M, **Immunizations** in this Policy Manual. Providers must coordinate with the Arizona Department of Health Services (ADHS) Vaccines for Children (VFC) program in the delivery of immunization services. Immunizations must be provided according to the Advisory Committee on Immunization Practices Recommended Schedule. (Refer to the CDC website.) The AdSS must ensure providers enroll and re-enroll annually with the VFC program, in accordance with contract requirements. The AdSS must not use funding from the Division to purchase vaccines covered through the VFC program for members younger than 19 years of age.

The AdSS must ensure providers:

a. Document each EPSDT-age member’s immunizations in the Arizona State Immunization Information System (ASIIS) registry.

b. Maintain the ASIIS immunization records of each EPSDT member in ASIIS, in accordance with A.R.S. § 36-135.

The AdSS must monitor provider’s compliance with immunization registry reporting requirements and take action to improve reporting when issues are identified.
2. **Eye Examinations and Prescriptive Lenses** - EPSDT covers eye examinations as appropriate to age, according to the AHCCCS EPSDT Periodicity Schedule, and as medically necessary using standardized visual tools. Vision exams provided in a PCP’s office during an EPSDT visit are not a separately billable service. Prescriptive lenses and frames are provided to correct or ameliorate defects, physical illness, and conditions discovered by EPSDT screenings, subject to medical necessity. Frames for eyeglasses are also covered.

3. **Blood Lead Screening** - EPSDT covers blood lead screening. Required blood lead screening for children under six years of age is based on the child’s risk as determined by either the member’s residential zip code or presence of other known risk-factors, as specified in the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning.

   a. Children living in a targeted high-risk zip code: All children living in a high risk zip code as identified by the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning must have a blood lead test at 12 and 24 months of age. Children between 36 and 72 months of age must receive a screening blood lead test, if they have not been previously screened for lead poisoning.

   b. Children living outside of the targeted high-risk zip codes: Children living in Arizona, but not in a targeted high-risk zip code must receive an individual risk assessment according to the AHCCCS periodicity schedule (when the child is 6, 9, 12, 18, and 24 months of age and then annually through age 6 years), with appropriate follow-up action taken for those children who are determined to be at high risk based on criteria included within the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning.

A blood lead test result, equal to or greater than 10 micrograms of lead per deciliter of whole blood obtained by capillary specimen or finger stick, must be confirmed using a venous blood sample. A verbal blood lead screening risk assessment must be completed at each EPSDT visit for children six through 72 months of age (six years of age) to assist in determining risk.

The AdSS must ensure that providers report blood lead levels equal to or greater than ten micrograms of lead per deciliter of whole blood to ADHS (A.A.C. R9-4-302).

The AdSS must implement protocols for:

   a. Care coordination for members with elevated blood lead levels (parents, PCP and ADHS) to ensure timely follow-up and retesting
b. Appropriate care coordination for an EPSDT child, who has an elevated blood lead level and is transitioning to or from another AdSS

c. Referral of members who lose AHCCCS or Division eligibility to low-cost or no-cost follow-up testing and treatment for those members that have a blood lead test result equal to or greater than ten micrograms of lead per deciliter of whole blood

Refer to Chapter 500, Care Coordination Requirements in this Policy Manual for more information related to transitioning members.


5. **Tuberculosis (TB) Screening** - EPSDT covers TB screening. The AdSS must implement protocols for care and coordination of members who received TB testing to ensure timely reading of the TB skin test and treatment, if medically necessary.

6. **Nutritional Assessment and Nutritional Therapy**

a. **Nutritional Assessments**

Nutritional assessments are conducted to assist EPSDT members whose health status may improve with nutritional intervention. The Division covers the assessment of nutritional status provided by the member's PCP as a part of the EPSDT screenings, as specified in the AHCCCS EPSDT Periodicity Schedule and on an inter-periodic basis, as determined necessary by the member’s PCP. The Division also covers nutritional assessments provided by a registered dietitian when ordered by the member’s PCP. This includes EPSDT-eligible members who are underweight or overweight.

To initiate the referral for a nutritional assessment, the PCP must use the AdSS referral form in accordance with AdSS protocols.

If a member qualifies for nutritional therapy due to a medical condition (as described in the Nutritional Therapy section below), the AdSS is the primary payor for:

i. Infant formulas above the amount provided through the WIC program or formula types deemed medically necessary that are not provided through the Women, Infants and Children (WIC) program

Note: This does not include formulas outside of those offered through the WIC program that are not medically
necessary, such as formula types selected based on brand preference.

For members, under the age of five, requiring formula types deemed medically necessary that are not provided through the WIC program, the AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (AMPM Exhibit 430-2) must be submitted directly to the member’s AdSS, as WIC is a secondary payor of specialty exempt formulas.

For members who are infants (0-1 year), requiring infant formulas above the amount provided through the WIC program, the AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (AMPM Exhibit 430-2) must be submitted directly to the member’s AdSS for the amount of formula that exceeds that provided through the WIC program.

Note: WIC is a secondary payor of infant formulas above the amount provided through the WIC program.

ii. Medical foods

iii. Parenteral feedings

iv. Enteral feedings.

If a member has a congenital metabolic disorder identified through the Bloodspot Newborn Screening Panel (such as Phenylketonuria, Homocystinuria, Maple Syrup Urine Disease, or Galactosemia), refer to Chapter 320-H, Metabolic Medical Food in this Policy Manual.

b. Nutritional Therapy:

The Division covers nutritional therapy for EPSDT-eligible members on an enteral, parenteral, or oral basis, when determined medically necessary to provide either complete daily dietary requirements or to supplement a member’s daily nutritional and caloric intake. The AdSS is the primary payor for parenteral and enteral feedings, unless nutritional therapy is covered by a member’s primary insurance.

i. Enteral nutritional therapy: Provides liquid nourishment directly to the digestive tract of a member who cannot ingest an appropriate amount of calories to maintain an acceptable nutritional status. Enteral nutrition is commonly provided by Jejunostomy tube (J-tube), Gastrostomy Tube (G-tube) or Nasogastric (N/G) tube. Refer to the specific AdSS for managed care members and the Division’s AIHP (Fee-For-Service) regarding Prior Approval (PA) requirements.
ii. Parenteral nutritional therapy: Provides nourishment through the venous system to members with severe pathology of the alimentary tract, which does not allow absorption of sufficient nutrients to maintain weight and strength. Refer to the Division for managed care members and the Division’s AIHP (Fee-For-Service) regarding PA requirements.

iii. Commercial Oral Supplemental Nutritional Feedings: Provides nourishment and increases caloric intake as a supplement to the member's intake of other age-appropriate foods, or as the sole source of nutrition for the member. Nourishment is taken orally and is generally provided through commercial nutritional supplements available without prescription.

PA is required from the member’s AdSS the Division for Fee-For-Service members for commercial oral nutritional supplements, unless the member is also currently receiving nutrition through enteral or parenteral feedings.

Medical necessity for commercial oral nutritional supplements must be determined by the member’s PCP or specialty provider, using the criteria specified in this policy. An example of a nutritional supplement is an amino acid-based formula used by a member for eosinophilic gastrointestinal disorder. The PCP or specialty provider must use the AHCCCS-approved form, AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (AMPM Exhibit 430-2) to obtain authorization from the member’s AdSS or the Division for FFS members.

The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must indicate which of the following criteria were met when assessing the medical necessity of providing commercial oral nutritional supplements.

(a) The member has been diagnosed with a chronic disease or condition, is below the recommended BMI percentile (or weight-for-length percentile for members less than two years of age) for the diagnosis per evidence-based guidance as issued by the American Academy of Pediatrics, and there are no alternatives for adequate nutrition.

OR:

(b) The member had met at least two of the following criteria to establish medical necessity:

• Is at or below the 10th percentile for weight-for-
length or BMI on the appropriate growth chart for age and gender, as recommended by the CDC, for three months or more.

- Reached a plateau in growth and/or nutritional status for more than six months, or more than three months if member is an infant less than one year of age.

- Demonstrated a medically significant decline in weight within the three month period prior to the assessment.

- Can consume/eat no more than 25% of his/her nutritional requirements from age-appropriate food sources.

Additionally, each of the following requirements must be met:

(a) The member has been evaluated and treated for medical conditions that may cause problems with growth (such as feeding problems, behavioral conditions or psychosocial problems, endocrine or gastrointestinal problems).

(b) The member has had a trial of higher caloric foods, blenderized foods, or commonly available products that may be used as dietary supplements for a period of no less than 30 days in duration. If it is determined through clinical documentation and other supporting evidence that a trial of higher caloric foods would be detrimental to the member’s overall health, the provider may submit the Certificate of Medical Necessity for Commercial Oral Nutritional Supplements located in the AHCCCS Medical Policy Manual, Exhibit 430-2), along with supporting documentation demonstrating the risk posed to the member, for the AdSS Medical Director or Designee’s consideration in approving the provider’s prior authorization request.

iv. Supporting documentation must accompany the Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (Members 21 Years of Age or Greater - Initial or Ingoing Requests). This documentation must demonstrate that the member meets all of the required criteria, and it includes:

(a) Initial Requests

Documentation demonstrating that nutritional
counseling has been provided as a part of the health risk assessment and screening services provided to the member by the PCP or specialty provider, or through consultation with a registered dietitian.

Clinical notes or other supporting documentation dated within three months of the request, providing a detailed history and thorough physical assessment demonstrating evidence of member meeting all of the required criteria, as indicated on the Certificate of Medical Necessity (The physical assessment must include the member’s current/past weight-for-length and BMI percentiles (if member is two years of age or older.)

Documentation detailing alternatives that were tried in an effort to boost caloric intake and/or change food consistencies that have proven unsuccessful in resolving the nutritional concern identified, and as member adherence to the prescribed dietary plan/alternatives attempted.

(b) Ongoing Requests

Subsequent submissions must include a clinical note or other supporting documentation dated within three months of the request, that includes the members overall response to supplemental therapy and justification for continued supplement use. This must include the member’s tolerance to formula, recent hospitalizations, current weight-for-length or BMI percentile (if member is two year of age or older).

Note: Members receiving nutritional therapy must be physically assessed by the member’s PCP, specialty provider, or registered dietitian at least annually.

Additionally, documentation demonstrating encouragement and assistance provided to the caregiver in weaning the member from supplemental nutritional feedings should be included, when appropriate.

c. AdSS Requirements

The AdSS must:

i. Develop guidelines for use by the PCP in providing:

• Information necessary to obtain PA for commercial oral
nutritional supplements

- Encouragement and assistance to the caregiver in weaning the member from the necessity for supplemental nutritional feedings

- Education and training, if the member’s parent or guardian elects to prepare the member’s food, regarding proper sanitation and temperatures to avoid contamination of foods that are blended or specially prepared for the member.

ii. Implement protocols for transitioning a child who is receiving nutritional therapy, to or from another AdSS or another service program (e.g., Women, Infants and Children).

iii. Implement a process for verifying medical necessity of nutritional therapy, through the receipt of supporting medical documentation dated within three months of the request, prior to giving initial or ongoing authorizations for nutritional therapy. Documentation must include clinical notes or other supporting documentation from the member’s PCP, specialty provider, or registered dietitian including a detailed history and thorough physical assessment that provides evidence of member meeting all of the required criteria, as indicated on the Certificate of Medical Necessity.

d. Provider Requirements

When requesting initial or ongoing Prior Authorization (PA) for commercial oral nutritional supplements, providers must ensure:

i. Documents are submitted with the completed Certificate of Medical Necessity to support all of the necessary requirements for Commercial Oral Nutritional Supplements as detailed above.

ii. If the member's parent or guardian elects to prepare the member's food, education and training regarding proper sanitation and temperatures to avoid contamination of foods that are blended or specially prepared for the member is provided.

iii. Ongoing monitoring is conducted to assess member adherence/tolerance to the prescribed nutritional supplement regimen and determine necessary adjustments to the prescribed amount of supplement are appropriate based on the member’s weight loss/gain.
iv. Documentation demonstrating encouragement and assistance provided to the caregiver in weaning the member from the necessity for supplemental nutritional feedings, when appropriate.

e. Oral Health Services – 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 is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan. Referral to a dentist or dental home must be made as outlined in policy. Refer to AHCCCS Dental Periodicity Schedule (AMPM Exhibit 431-1) for more details pertaining to covered services, and provider and AdSS requirements.

7. Cochlear and Osseointegrated Implantation

a. Cochlear Implantation

Cochlear implantation provides an awareness and identification of sounds and facilitates communication for persons who have profound, sensorineural hearing loss (nerve deafness). Deafness may be prelingual/perilingual or postlingual. The Division covers medically necessary services for cochlear implantation solely for member of EPSDT age. Cochlear implantation is limited to one functioning implant per member. The Division will not cover cochlear implantation in instances where individuals have one functioning cochlear implant.

i. Candidates for cochlear implants must meet criteria for medical necessity, including but not limited to, the following indications:

- A diagnosis of bilateral profound sensorineural deafness (using age-appropriate standard testing), with little or no benefit from a hearing (or vibrotactile) aid, as established by audilogic and medical evaluation

- Presence of an accessible cochlear lumen structurally suited to implantation, with no lesions in the auditory nerve and acoustic areas of the central nervous system, as demonstrated by CT scan or other appropriate radiologic evaluation

- No known contraindications to surgery

- Demonstrated age-appropriate cognitive ability to use auditory clues
• The device must be used in accordance with the FDA approved labeling.

ii. Coverage of cochlear implantation includes:

• Complete auditory testing and evaluation by an otolaryngologist, speech-language pathologist or audiologist

• Presurgery inpatient/outpatient evaluation by a board certified otolaryngologist

• Diagnostic procedures and studies, including CT scan or other appropriate radiologic evaluation, for determining candidacy suitability

• Preoperative psychosocial assessment/evaluation by psychologist or counselor

• Prosthetic device for implantation (must be non-experimental/non-investigational and be Food and Drug Administration approved and used according to labeling instructions)

• Surgical implantation and related services

• Postsurgical rehabilitation, education, counseling and training

• Equipment maintenance, repair and replacement of the internal/external components or both if not operating effectively and is cost effective. Examples include but are not limited to: the device is no longer functional or the used component compromises the member’s safety. Documentation that establishes the need to replace components not operating effectively must be provided at the time prior authorization is sought.

Cochlear implantation requires PA from the AdSS Medical Director, or from the Division Medical Director or designee for Division AIHP (Fee-For-Service) members.

b. Osseointegrated Implants (Bone Anchored Hearing Aid [BAHA])

Coverage of medically necessary services for osseointegrated implantation is limited to EPSDT members. Osseointegrated implants are devices, implanted in the skull, that replace the function of the middle ear and provide mechanical energy to the cochlea via a
mechanical transducer. These devices are indicated only when hearing aids are medically inappropriate or cannot be used due to congenital malformation, chronic disease, severe sensorineural hearing loss or surgery. Osseointegrated implantation requires PA from the Division Medical Director, or from the Division Medical Director or designee, for Division AIHP (Fee-For-Service) members. Maintenance is the same as in Item 7.a.ii above.

8. Conscious Sedation – The Division covers conscious sedation for members receiving EPSDT services. Conscious sedation provides a state of consciousness that allows the member to:
   a. Tolerate an unpleasant procedure while continuously maintaining adequate cardiovascular and respiratory function.
   b. Respond purposely to verbal command and/or tactile stimulation.

   Except as specified below, coverage is limited to:
   a. Bone marrow biopsy with needle or trocar
   b. Bone marrow aspiration
   c. Intravenous chemotherapy administration, push technique
   d. Chemotherapy administration into central nervous system by spinal puncture
   e. Diagnostic lumbar spinal puncture
   f. Therapeutic spinal puncture for drainage of cerebrospinal fluid.

   Additional applications of conscious sedation for members receiving EPSDT services are considered on a case-by-case basis and require medical review and prior authorization by the AdSS Medical Director for enrolled members or by the Division Chief Medical Officer or designee for Division AIHP (Fee-For-Service) members.

9. Behavioral Health Services –

   The Division covers behavioral health services for members eligible for EPSDT services, as described in Policy 310 of this Policy Manual. EPSDT behavioral health services include the services listed in 42 U.S.C. 1396d (a) necessary to correct or ameliorate mental illnesses and conditions discovered by the screening services whether or not the services are covered under the (AHCCCS) State Plan.

   The Division has adopted the following AHCCCC Medical Policy Manual appendices: Appendix E for children and adolescents and Appendix F for adults. For the diagnosis of Attention Deficit Disorder/Attention Deficit
Hyperactivity Disorder (ADHD), depression (including postnatal depression), and/or anxiety disorders, there are clinical guidelines that include assessment tools and algorithms. PCPs are to use the clinical guidelines as an aid in treatment decisions. PCPs that prescribe medications to treat ADHD, depression, or anxiety disorders must complete an annual assessment of the member’s behavioral health condition and treatment plan. The AdSS must establish a medication management process that results in the annual assessment being completed by the PCP in order for ADHD, depression, and anxiety medication prescriptions to continue beyond a 12-month period. To ensure there is not a gap in medications for these conditions, the AdSS must identify and conduct outreach to members approaching the 12-month reassessment timeframe and provide assistance in scheduling the appointment with the member’s PCP.

The Division has implemented the following 12 Principles to maintain the integrity of the best practices and approaches to providing behavioral health services for children. The AdSS must integrate these principles in the provision of behavioral health services for members of EPSDT age:

a. **Collaboration with the Child and Family:** Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes. Parent and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.

b. **Functional Outcomes:** Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Implementation of the behavioral health services plan stabilizes the child’s condition and minimizes safety risks.

c. **Collaboration with Others:** When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented. Client centered teams plan and deliver services. Each child’s team includes the child, parents, any foster parent, and any individual important in the child’s life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including as appropriate, the child’s teacher, the child’s Department of Child Safety case worker and/or Division of Developmental Disabilities Support Coordinator, and the child’s probation officer. The team develops a common assessment of the child’s and family’s strengths and needs, develops an Individualized Service Plan/Person Centered Plan and monitors the implementation of the plan and makes adjustments in the plan if it is not succeeding.

d. **Accessible Services:** Children have access to a comprehensive array
of behavioral health services, sufficient to ensure that they receive the treatment they need. Case management is provided as needed. Behavioral health services plans identify transportation the parents and the child need to access behavioral health services, and how transportation assistance will be provided. Behavioral health services are adapted or created when they are needed but not available.

e. Best Practices: Behavioral health services are provided by competent individuals who are adequately trained and supervised. Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, the need for stability and the need to promote permanency in the members' lives, especially members in foster care. Behavioral health services are continuously evaluated and modified if ineffective in achieving desired outcomes.

f. Most appropriate setting: Children are provided behavioral health services in their home and community to the extent possible. Behavioral health services are provided in the most integrated setting appropriate to meet the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's needs.

g. Timeliness: Children identified as needing behavioral health services are assessed and served promptly.

h. Services tailored to the child and family: The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.

i. Stability: Behavioral health service places strive to minimize multiple placements. Service plans identify whether a member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk. Behavioral health service plans anticipate crisis that might develop and include specific strategies and services that will be employed if a crisis develops. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and the criminal justice system. Behavioral health service plans anticipate and appropriately plan for transition in children's lives, including transitions to new schools and new placements, and
transitions to adult services.

j.  Respect for the child and family’s unique cultural heritage: Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.

k.  Independence: Behavioral health services include support and training for parents in meeting their child’s behavioral health needs, and support and training for children in self-management. Behavioral health service plans identify parents’ and children’s needs for training and support to participate as partners in the assessment process, and in the planning and delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with the understanding of written materials, will be made available.

l.  Connection to natural supports: The behavioral health system identifies and appropriately uses natural supports available from the child and parents’ own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

Note: PCPs are encouraged to implement postpartum depression screenings to identify and refer mothers who would benefit from additional treatment due to concerns related to postpartum depression during EPSDT visits for infants up to one year of age.

11. Religious Non-medical Health Care Institution Services – The Division covers religious non-medical health care institution services for members eligible for EPSDT services as described in Division Medical Policy Manual Chapter 300, Policy 310.

12. Care Management Services – The Division covers care management services for physical and behavioral health care, as appropriate for members eligible for EPSDT services. In EPSDT, care management involves identifying the health needs of a child, ensuring necessary referrals are made, maintaining health history, and initiating further evaluation/diagnosis and treatment when necessary.

13. Chiropractic Services – The Division covers chiropractic services to members eligible for EPSDT services, when ordered by the member’s PCP and approved by the AdSS in order to ameliorate the member’s medical condition.

14. Personal Care Services – The Division covers personal care services, as appropriate, for members eligible for EPSDT services.
15. Incontinence Briefs

a. The AdSS must provide incontinence briefs, including pull-ups and incontinence pads, for members between 3 and 21 years of age and who are eligible for ALTCS. 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 when:

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

ii. The PCP or attending physician has issued a prescription ordering the incontinence briefs.

iii. 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.

iv. The member obtains incontinence briefs from providers in the AdSS network.

v. Appropriate prior authorization requirements are applied. 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:

- The member is over age 3 and under age 21.
- The member has a disability that causes incontinence of bladder and/or bowel.
- 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 AdSS.
- The prescription is for 240 briefs or fewer per month, unless evidence of medical necessity for over 240 briefs is provided.

b. The Division provides incontinence briefs for members who are between 3 and 21 years of age who are:

i. Group home residents that do not qualify for Medicaid (ALTCS or targeted).
ii. Group home residents that qualify for Medicaid (ALTCS) and have been denied incontinence briefs by the AdSS and other medical insurance coverage (e.g., Medicare), if applicable.

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

d. The AdSS may require a new prior authorization to be issued no more frequently than every 12 months.

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

f. 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.

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

h. 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.)

16. Medically Necessary Therapies – The Division covers medically necessary therapies, including physical therapy, occupational therapy, and speech therapy, necessary to correct or ameliorate defects, physical and mental illnesses, and conditions discovered by the screening services.

When medically necessary, inpatient and outpatient therapies are covered. For children identified by the PCP as needing early intervention services, the AdSS must provide services in the natural environment whenever possible.

The Division has adopted Exhibit 430-3 in the AHCCCS Medical Policy Manual, to Procedures for the Coordination of Services under Early Periodic Screening, Diagnostic and Treatment, and Early Intervention (AMPM Exhibit 430-3). This Exhibit provides more information related to the coordination and referral process for early intervention services.

D. Sick Visit Performed in Addition to an EPSDT Visit

Billing of a “sick visit” (CPT Codes 99201-99215) at the same time as an EPSDT is a separately billable service if:

1. An abnormality is found or a preexisting problem is addressed while performing an EPSDT service and the problem or abnormality requires more work to perform the key components of a problem-oriented E/M service.

2. The “sick visit” is documented on a separate note.
3. History, Exam, and Medical Decision Making components of the separate “sick visit” already performed during the course of an EPSDT visit are not to be considered when determining the level of the additional service (CPT Code 99201-99215).

4. The current status (not history) of the abnormality or preexisting condition is the basis of determining medical necessity.

Modifier 25 must be added to the Office/Outpatient code to indicate that a significant, separately identifiable evaluation and management service was provided by the same physician on the same day as the preventive medicine service.

Acute diagnosis codes not applicable to the current visit should not be billed.

An insignificant or trivial problem/abnormality that is encountered during the preventive medicine evaluation and management service, but does not require additional work and the performance of the key components of a problem-oriented E/M service, is included in the EPSDT visit and should not be reported.

E. Requirements for Providing EPSDT Services

The AdSS must:

1. Develop policies and procedures to:
   a. Identify the needs of EPSDT-age members, inform members of the availability of EPSDT services, coordinate their care, provide care management, conduct appropriate follow up, and ensure members receive timely and appropriate treatment.
   b. Monitor, evaluate, and improve EPSDT participation.

2. Employ sufficient numbers of appropriately qualified local personnel to meet the health care needs of members and fulfill federal, state, and contractual EPSDT requirements.

3. Inform all participating PCPs about EPSDT requirements and monitor compliance with the requirements.

   This must include informing PCPs of Federal, State and AHCCCS and Division policy requirements for EPSDT and updates of new information as it becomes available.

4. Ensure PCPs providing care to children are trained to use implemented developmental screening tools. This will also include a process to monitor the use of an approved developmental screening tools (ASQ and PEDS Tool) for members at 9, 18, and 24 months of age. The MCHAT may be used for members 16-30 months of age to assess the risk of autism spectrum disorders in place of the ASQ or PEDS Tool when medically indicated. Providers are expected to be trained as specified by the American Academy of
Pediatrics, in order for the PCP to obtain additional reimbursement for use of an approved developmental screening tool during an EPSDT visit.

Note: Approved developmental screening tool training resources may be found on the Arizona Department of Health Services website.

5. Develop, implement, and maintain a program to inform members about EPSDT services within 30 days of enrollment with the AdSS. This information must include:

a. The benefits of preventive health care
b. Information that an EPSDT visit is a well-child visit
c. A complete description of the services available as described in this section
d. Information on how to obtain these services and assistance with scheduling appointments
e. Availability of care management assistance in coordinating EPSDT covered services
f. A statement that there is no copayment or other charge for EPSDT screening and resultant services, and
g. A statement that assistance with medically necessary transportation and scheduling appointments is available to obtain EPSDT services.

6. The AdSS must conduct written and other member educational outreach related to immunizations, available community resources (WIC, AzEIP, and Head Start), dangers of lead exposure and recommended/mandatory testing, childhood obesity and prevention measures, age-appropriate risk prevention efforts (addressing injury and suicide prevention, bullying, violence, and risky sexual behavior), education on importance of using PCP in place of ER visits for non-emergent concerns, recommended 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; each topic must be covered during the twelve month period. EPSDT related outreach material, must include a statement informing members that an EPSDT visit is synonymous to a well-child visit. The Division has adopted Exhibit 400-3 in the AHCCCS Medical Policy Manual, AHCCCS Maternal Child Health/EPSDT Member Outreach which serves as an easy reference guide regarding member outreach.

Outreach requirements for AdSS are included in the Division’s Operations Policy Manual, Chapter 404.

7. Provide EPSDT information (as defined in paragraphs #5 and #6 above), in a second language, in addition to English, in accordance with the
requirements of the in Chapter 405-Cultural Competency in the Division’s Operations Manual, Chapter 405.

8. Develop and implement processes to assist members and their families regarding community health resources, including but not limited to WIC, AzEIP, and Head Start.

9. Develop and implement processes to ensure the identification of member’s needing care management services and the availability of care management assistance in coordinating EPSDT covered services.

10. Participate in community and/or quality initiatives, to promote and support best local practices and quality care, within the communities served by the AdSS.

11. Attend EPSDT-related meetings when requested by the Division.

12. Coordinate with other entities when the AdSS determines a member has other payor coverage.

13. Develop, implement, and maintain a procedure for ensuring timeliness and care coordination of re-screening and treatment for all conditions identified, including behavioral health services, as a result of examination, screening, and diagnosis. Treatment, if required, must occur on a timely basis, generally initiating services no longer than six months beyond the request for screening services, unless stated otherwise in this policy (refer to the AdSS Requirements section of this Policy).

14. Develop, implement, and maintain a process to provide appropriate follow-up care for members who have abnormal blood lead test results.

15. Develop and implement a process for monitoring that providers use the most current EPSDT Tracking Forms at every EPSDT visit and that all age-appropriate screenings and services are conducted during each visit. If an electronic medical record is used, the electronic medical record must include all of the elements of the most current age-appropriate EPSDT Tracking Form.

16. Develop, implement, and maintain a procedure to notify all members/responsible parties of visits required by the AHCCCS EPSDT and Dental Periodicity Schedules. Processes other than mailings must be pre-approved by the Division. This procedure must include:
   a. Notification to members or responsible parties regarding due dates of each EPSDT visit. If an EPSDT visit has not taken place, a second written notice must be sent.
   b. Notification to members or responsible parties regarding due dates of biannual (one visit every six months) dental visits. If a dental visit has not taken place, a second notice must be sent.
18. Develop and implement processes to reduce no-show appointment rates for EPSDT services, and provide targeted outreach to those members who did not show for appointments.

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

19. Implement processes to print two part carbonless EPSDT Tracking Forms (a copy for the medical record and a copy for providers to send to the AdSS Maternal Child Health/EPSDT Coordinator).

20. Distribute EPSDT Tracking Forms to contracted providers who do not use and submit electronic EPSDT forms to the AdSS.

21. Require the use of the AHCCCS EPSDT and Dental Periodicity Schedules and approved, standardized EPSDT Tracking Forms by all contracted providers. The AHCCCS EPSDT and Dental Periodicity Schedules give providers necessary information regarding timeframes in which age-related required screenings and services must be rendered by providers.

The AdSS must require providers to complete all of the following requirements:

a. Use the EPSDT Tracking Forms (or electronic equivalent) at every EPSDT visit. The AdSS must monitor the anticipated volume of EPSDT Tracking Forms received based on the number and age of the PCPs EPSDT age member panel.

b. Perform all age-appropriate screening and services during each EPSDT visit in accordance with the AHCCCS EPSDT and Dental Periodicity Schedules, including, but not limited to, using the approved developmental screening tools, as described in this Chapter.

c. Sign EPSDT Tracking Forms and place them in the member’s medical record. If an electronic medical record is used, an electronic signature by the provider must be included.

d. Send copies of the EPSDT Tracking Forms (or electronic equivalent) to the AdSS. Providers are not required to submit EPSDT Tracking Forms to the Division.

e. Providers of Fee-For-Service members must maintain a copy of the EPSDT Tracking Forms (or electronic equivalent), per Division policy, in the medical record. Providers do not need to send copies to the Division. If an electronic medical record is used, an electronic signature by the provider must be included.

22. Submit the EPSDT/Adult Monitoring and Performance Measure Quarterly Report to the Division, a detailed progress report that describes the activities
of the quarter and the progress made in reaching the established goals of the plan, within 15 days of the end of each reporting quarter. The Division has adopted Exhibit 400-1-Maternal and Child Health Reporting Requirements in the AHCCCS Medical Policy Manual that outlines the requirements. Quarterly reports must include documentation of monitoring and evaluation of EPSDT requirements, and implementation of improvement processes. The quarterly report must include results of ongoing AdSS monitoring of performance rates, in a format that will facilitate comparison of rates in order to identify possible need for interventions to improve or sustain rates. The report must also identify the goals established by the AdSS; see EPSDT/Adult Monitoring and Performance Measure Quarterly Report (AMPM Appendix A), which has been adopted for use by the Division.

23. Participate in an annual review of EPSDT requirements conducted by the Division; including, but not limited to, AdSS results of on-site visits to providers and medical record audits.

24. Include language in PCP contracts that requires PCPs to:
   a. Provide EPSDT services for all assigned members from birth to 21 years of age in accordance with the AHCCCS EPSDT and Dental Periodicity Schedules.
   b. Agree to use the standardized AHCCCS EPSDT Tracking Forms or, if electronic medical records are use, they must contain all the elements of the current AHCCCS EPSDT Tracking Forms.
   c. Implement procedures to ensure compliance by PCPs with all EPSDT standards and contract requirements.
   d. Implement protocols to ensure that health problems are diagnosed and treated early, before they become more complex and the treatment more costly (including follow-up related to blood lead screening and tuberculosis screening).
   e. Have a process for to assisting members in navigating the healthcare system, as well as inform members of any other community-based resources that support optimal health outcomes, to ensure members receive appropriate support services.
   f. Implement protocols for coordinating care and services with the appropriate state agencies for members eligible for EPSDT, and ensure members are referred to support services, as well as other community-based resources to support good health outcomes.
   g. Refer eligible members to Head Start and the special supplemental nutrition program for Women, Infants and Children (WIC), for WIC approved formula and support services. Ensure medically necessary nutritional supplements are covered by the AdSS (For more
h. Use the criteria specified in this policy when requesting medically necessary nutritional supplements (refer Nutritional Assessment and Nutritional Therapy section of this policy and Exhibit 430-2, AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements in the AHCCCS Medical Policy Manual.

i. Coordinate with Arizona Early Intervention Program (AzEIP) to identify children 0-3 years of age with developmental disabilities needing services, including family education and family support needs focusing on each child’s natural environment, to optimize child health and development (EPSDT services, as defined in A.A.C. R9-22-201 et seq, must be provided by the AdSS). AdSS must require their providers to communicate results of assessments and services provided to AzEIP enrollees within 45 days of the member’s AzEIP enrollment. Refer to Procedures for the Coordination of Services Under EPSDT and Early Intervention in the AHCCCS Medical Policy Manual (AMPM Exhibit 430-3) for more information related to the coordination and referral process for early interventions services.

25. Educate providers to comply with AHCCCS/AzEIP in the AMPM Exhibit 430-3, when the need for medically necessary services are identified for members birth to three years of age. This includes:

a. Ensuring medically necessary services are initiated within 45 days of a completed Individual Family Service Plan (IFSP), when services are requested by the AzEIP service coordinator.

b. Reimbursing all AHCCCS registered AzEIP providers, whether or not they are contracted with the AdSS. Non-contracted AHCCCS registered AzEIP providers will be reimbursed for authorized services at the Fee-For-Service (FFS) rates. IFSP services must be reviewed for medical necessity prior to reimbursement.

26. Provide education and assists with referrals of eligible members to the special supplemental nutrition program for Women, Infants and Children (WIC), for WIC approved formula and support services and ensures medically necessary nutritional supplements are covered. Refer to C, EPSDT Service Standards and Nutritional Assessment and Nutritional Therapy sections of this policy and Exhibit 430-2, AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements in the AHCCCS Medical Policy Manual.

27. Provide education and assists with referrals of eligible members to Head Start to ensure eligible members receive appropriate EPSDT services to optimize child health and development.

F. Each AdSS must have a written EPSDT Annual Plan that addresses minimum AdSS
requirements as specified in the prior section (Requirements for Providing EPSDT Services and Requirements for Oral Health Care), as well as the objectives of the AdSS’ program that are focused on achieving Division and AHCCCS requirements. It must also incorporate monitoring and evaluation activities for these minimum requirements (see Exhibit 400-2B, EPDST Annual Plan Checklist).

The EPSDT Annual Plan must be submitted to the Division Health Care Services unit through the Division’s Compliance Unit no later than December 15th for review and approval; see Maternal and Child Health Reporting Requirements (AMPM Exhibit 400-1). The written EPSDT Annual Plan must contain, at a minimum, the following:

1. EPSDT Narrative Plan – A written description of all planned activities to address the Division’s minimum requirements for EPSDT services, as specified in the prior section (AdSS Requirements for Providing EPSDT Services), including, but not limited to, informing providers and members that EPSDT is a comprehensive child health program of prevention, treatment, correction, and improvement (amelioration) of physical and behavioral/mental health problems for members under the age of 21. The narrative description must also include AdSS activities to identify member needs, coordination of care, and follow-up activities to ensure appropriate treatment is received in a timely manner.

2. EPSDT 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.

3. EPSDT Work Plan that includes:
   a. Specific measurable objectives based on Division established Minimum Performance Standards. When Division Minimum Performance Standards have been met, other generally accepted benchmarks that continue the improvement efforts by the AdSS 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 EPSDT program when Minimum Performance Standards have been met. Objectives must include a focus toward blood lead testing and follow-up for abnormal blood lead test levels identified, childhood obesity, care coordination efforts, and member utilization.
   b. Strategies and specific measurable interventions to accomplish objectives (e.g., member outreach, provider education and provider compliance with mandatory components of the EPSDT 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 EPSDT Annual Plan, submitted as separate attachments.

G. Fee-for-Service/EPSDT Provider Requirements

This section discusses the procedural requirements for FFS EPSDT service providers. FFS providers must:

1. Provide EPSDT services in accordance with 42 U.S.C. 1396d(a) and (r), 1396a (a) (43), 42 CFR 441.50 et seq., AHCCCS rules, and AHCCCS and Division policies.

2. Provide and document EPSDT screening services in accordance with the AHCCCS EPSDT and Dental Periodicity Schedules.

3. Refer members for follow up, diagnosis and treatment, ensuring that treatment is initiated within 60 days of screening services.

4. If appropriate, document in the medical record the member’s or responsible person’s decision not to use EPSDT services or receive immunizations.

5. Document a health database assessment on each EPSDT participant. The database must be interpreted by a physician or licensed health professional who is under the supervision of a physician, and provide health counseling/education at initial and follow up visits.

H. Claim Forms

Claims for EPSDT services must be submitted on a CMS (formerly HCFA) 1500 form. Providers must bill for preventative EPSDT services using the preventative service, office or other outpatient services and preventive medicine CPT codes (99381 – 99385, 99391 – 99395) with an EP modifier. EPSDT visits are paid at a global rate for the services specified in this Chapter. With the exception of those items listed above as separately reimbursable services, no additional reimbursement is allowed. Providers must use an EP modifier to designate all services related to the EPSDT well child check-ups, including routine vision and hearing screenings.
431 ORAL HEALTH CARE (EPSDT-AGE MEMBERS)

EFFECTIVE DATE: October 1, 2019
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 Division members under 21 years of age who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. 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: As expeditiously as the member’s health condition requires but no later than three days of request
Routine: Within 45 calendar 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, including 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.

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**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 AdSS 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 planning, 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.

Informed 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) and

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 Division members 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.

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.

H. Adhere to the Dental Uniform Prior Authorization List (List) as agreed upon by the AdSS. Refer to the AHCCCS website under Resources: Guides- Manuals-Policies. All requests for changes to the List must be submitted to the AHCCCS DHCM designated Operations and Compliance Officer for review. Requests must include supporting documentation and rationale for the proposed changes.

I. (Effective 08/01/18) Adhere to the Uniform Warranty List as agreed upon by the AdSS. Refer to the AHCCCS website under Resources- Guides- Manuals-Policies. All requests for changes to the list must be submitted to the AHCCCS DHCM designated Operations and Compliance Officer for review. Requests must include supporting documentation and rationale for the proposed changes.

Note: The Division will reach out to AIHP members under age 21 to provide education and resources regarding dental/oral health services.

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.

**AFFILIATED PRACTICE DENTAL HYGIENIST**

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

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

B. A current copy of the affiliated practice agreement between the dentist and the affiliated practice hygienist and notification when changes to this agreement are made or the agreement is terminated.

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

D. When practicing under the scope of an affiliated practice dental hygienist, the affiliated practice dental hygienist must register with AHCCCS and must be identified as the treating provider under his or her individual AHCCCS provider identification number / NPI number. In addition, if the services are to be billed to an AdSS, the affiliated practice dental hygienist and the dentist with whom he or she is affiliated must be a credentialed network provider of the AdSS.
E. The affiliated practice dental hygienist will only be reimbursed for providing services in accordance with state statute and regulations, AHCCCS/Division policy and provider agreement, and their affiliated practice agreement.

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

Refer to AMPM Chapter 820 for information related to prior authorization requirements.
450 OUT-OF-STATE PLACEMENTS FOR CHILDREN OR YOUNG ADULTS FOR BEHAVIORAL HEALTH TREATMENT

EFFECTIVE DATE: October 1, 2019
REFERENCES: AHCCCS Behavioral Health Covered Services Guide, AMPM Exhibit 450-1
DELIVERABLES: Out of State Placements

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The Division contracts with AdSS and delegates the responsibility of implementing this policy.

The purpose of this Policy is to provide criteria and procedures for the Division’s AdSS in the event that an out-of-state placement is clinically necessary and supported by the Child and Family Team (CFT) or Adult Recovery Team (ART).

It may be necessary to consider an out-of-state placement for a child or young adult eligible for the Division to meet the member’s unique circumstances or clinical needs. The following factors may lead a member’s CFT or ART to consider the temporary out-of-state placement:

A. The member requires specialized programming not currently available in Arizona to effectively treat a specified behavioral health condition.

B. An out-of-state placement’s approach to treatment incorporates and supports the unique cultural heritage of the member.

C. A lack of current in-state bed capacity, and/or

D. Geographical proximity encourages support and facilitates family involvement in the member’s treatment.

General Requirements

Decisions to place members in out-of-state placements for behavioral health care and treatment must be examined and made after the CFT or ART have reviewed all other in-state options. Other options may include single case agreements with in-state providers or the development of an Individual Service Plan (ISP) that incorporates a combination of support services and clinical interventions.

Services provided out-of-state must meet the same requirements as those rendered in-state. AdSS must also ensure that out-of-state providers follow all Division reporting requirements, policies, and procedures, including appointment standards and timelines specified in AdSS Operations Manual, Policy 417.

Out of state placement providers must coordinate with the AdSS to provide required updates.
The following circumstances must exist in order to consider an out-of-state placement for a member:

A. The CFT or ART explore all applicable and available in-state services and placement options and,
   1. Determine that the services do not adequately meet the specific needs of the member, or
   2. In-state facilities decline to accept the member.

B. The member’s family/guardian agrees with the out-of-state placement (for minors and members between 18 and under 21 years of age under guardianship).

C. The out-of-state placement is registered as an AHCCCS provider.

D. Prior to placement, the AdSS ensures the member has access to non-emergent medical needs by an AHCCCS registered provider,

E. The out-of-state placement meets the Arizona Department of Education Academic Standards, and

F. A plan for the provision of non-emergency medical care is established.

**Conditions Before a Referral for Out-of-State Placement is Made**

The AdSS must ensure that documentation in the clinical record indicates the following conditions have been met before a referral for an out-of-state placement is made:

A. All less restrictive, clinically appropriate approaches have either been provided or considered by the CFT or ART and found not to meet the member’s needs.

B. A minimum of three in-state facilities have declined to accept the member.

C. The CFT or ART has been involved in the service planning process and is in agreement with the out-of-state placement.

D. The CFT or ART has documented how they will remain active and involved in service planning once the out-of-state placement has occurred.

E. An ISP has been developed.

F. All applicable prior authorization requirements have been met, including a second-level review completed by the Division’s Chief Medical Officer/designee.

G. The Arizona Department of Education has been consulted to ensure that the educational program in the out-of-state placement meets the Arizona Department of Education Academic Standards and the specific educational needs of the member.

H. Coordination has occurred with all other state agencies involved with the member, including notification to the Medical Director of the Division of Developmental Disabilities (DDD).
I. Coordination has occurred between the member’s primary care provider and the AdSS to develop a plan for the provision of any necessary, non-emergency medical care. The AdSS must identify who is responsible for this coordination. All providers are registered AHCCCS providers.

**Individual Service Plan (ISP)**

For a member placed out-of-state, the ISP developed by the CFT or ART (including the member’s Support Coordinator) must require that:

A. Discharge planning is initiated at the time of admission and includes:
   1. The measurable treatment goals being addressed by the out-of-state placement and the criteria necessary for discharge back to in-state services
   2. The possible or proposed in-state residence where the member will be returning
   3. The recommended services and supports required once the member returns from the out-of-state placement
   4. How effective strategies implemented in the out-of-state placement will be transferred to the members’ subsequent in-state placement
   5. The actions necessary to integrate the member into family and community life upon discharge, and
   6. Review by the CFT or ART of the member’s progress with the clinical staff at least every 30 days.

B. When appropriate, the member’s family/guardian is involved throughout the duration of the placement. Involvement may include family counseling in person or by teleconference or video-conference.

Home passes are allowed as clinically appropriate and in accordance with the AHCCCS Behavioral Health Covered Services Guide. For youth in Department of Child Safety (DCS) custody, approval of home passes are determined in collaboration with DCS.

C. The member’s needs, strengths, and cultural considerations have been addressed.

**Initial Notification to Division Health Care Services**

A. The AdSS must notify the Division by emailing a completed AHCCCS Out-of-State Placement Form (AMPM Exhibit 450-1, adopted by the Division for use by the AdSS) to Division Health Care Services under the following circumstances:
   1. Upon notification or discovery that a member is in an out-of-state behavioral health residential treatment facility
   2. Prior to a referral for an out of state placement (approval from the Division of
Division of Developmental Disabilities
Administrative Services Subcontractors
Medical Policy Manual
Chapter 400
Medical Policy for Maternal and Child Health

all planned out of state placements must be obtained prior to making a referral for out-of-state placement, in accordance with the criteria outlined in this Policy)


B. Prior authorization is required for all out-of-state placements.

C. The Division Health Care Services will review the information on the AHCCCS Out-of-State Placement Form (Exhibit 450-1) and render an approval within 1-3 business days. If the information is incorrect or incomplete, the form will be returned for correction. The corrected form must be resubmitted for approval.

Required Updates to Division Health Care Services

A. The AdSS must submit updates to the Division Health Care Services regarding the member’s progress in meeting the identified criteria for discharge.

B. The progress update, using the AHCCCS Out-of-State Placement Form (Exhibit 450-1), must be emailed to Division Health Care Services every 30 days that the member remains in the out-of-state placement. The 30-day update timeline is based upon the date of Division approval of the out-of-state placement. If a 30-day update date falls on a weekend or holiday, it must be submitted on the next business day.

Required Reporting of an Out-of-State Provider

All out-of-state providers are required to meet the reporting requirements of all incidences of injury/accidents, abuse, neglect, exploitation, healthcare acquired conditions, injuries from seclusion/restraint implementations as described in Division Medical Manual Policy 960.
510 PRIMARY CARE PROVIDERS

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 36-2901; A.R.S. Title 32, Chapter 13 or Chapter 17; A.R.S. Title 32, Chapter 25; A.R.S. Title 32, Chapter 15

This policy applies to the Division's Administrative Services Subcontractors (AdSS).

Definitions

A. Medication Assisted Treatment (MAT) - The use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of substance use disorders and can help some people to sustain recovery.

B. Primary Care Provider (PCP) - An individual who meets the requirements of A.R.S. § 36-2901 and who is responsible for the management of the member’s health care. A PCP may be a physician defined as a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17, or a practitioner defined as a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15. The PCP must be an individual, not a group or association of persons, such as a clinic.

Primary Care Provider Role and Responsibilities

The primary responsibilities of Primary Care Provider (PCP) include, but are not be limited to:

A. Providing initial and primary care services to assigned members

B. Initiating, supervising, and coordinating referrals for specialty care and inpatient services, and maintaining continuity of member care

C. Maintaining the member's medical record.

Provision of Initial and Primary Care Services

The PCP is responsible for rendering, or ensuring the provision of, covered preventive and primary care services to the member. These services include, at a minimum:

A. Treatment of routine illness

B. Maternity services if applicable

C. Immunizations

D. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for members under age 21

E. Adult health screening services

F. Medically necessary treatments for conditions identified in an EPSDT or adult health screening
G. Each member eligible for EPSDT must receive health screening/examination services as specified in Chapter 400 of this Policy Manual.

Behavioral Heal Medications Prescribed by the PCP for the Treatment of Anxiety, Depression, Attention Deficit Hyperactivity Disorder (ADHD) and Opioid Use Disorder (OUD)

The Division and its AdSS shall provide coverage for medically necessary, cost-effective, and federally and state reimbursable behavioral health medications prescribed by a PCP when used to treat anxiety, depression (including postpartum depression), ADHD, and/or OUD, this includes the monitoring and adjustments of behavioral health medications. For OUD the PCP must refer the member to a behavioral health provider for the psychological and/or behavioral therapy component of the MAT model and coordinate care with the behavioral health provider.

**Primary Care Provider Care Coordination Responsibilities**

PCPs, in their care coordination role, serve as the referral agent for specialty and referral treatments and services provided to the members eligible for the Division who are assigned to them, and they attempt to ensure coordinated quality care that is efficient and cost effective. Coordination responsibilities include, but are not limited to:

A. Referring members to providers or hospitals within the AdSS’s network, as appropriate, and if necessary, referring members to out-of-network specialty providers

B. Coordinating with the AdSS in prior authorization procedures for members

C. Conducting follow-up (including maintaining records of services provided) for referral services that are rendered to their assigned members by other providers, specialty providers, and/or hospitals

D. Coordinating the medical care of members assigned to them, including at a minimum:

1. Oversight of drug regimens to prevent negative interactive effects
2. Follow-up for all emergency services
3. Coordination of inpatient care
4. Coordination of services provided on a referral basis
5. Assurance that care rendered by specialty providers is appropriate and consistent with each member’s health care needs.
Maintenance of the Members Medical Record

Refer to Division Medical Policy Manual, Policy 940, Medical Records and Communication of Clinical Information, for information regarding the maintenance of the member's medical record.

Primary Care Provider Assignment and Appointment Standards

The AdSS must:

- Make provisions to ensure that newly enrolled members are assigned to a PCP and notified after the assignment within 12 calendar days of the enrollment notification.
- Ensure that PCPs under contract with them register with the AHCCCS Administration as an approved service provider and receive an AHCCCS provider ID number.

AHCCCS allows licensed providers from several medical disciplines to qualify as PCPs. These medical disciplines include physicians and certified nurse practitioners in the specialty areas of general practice, family practice, pediatrics, internal medicine, and obstetrics and gynecology. In addition, physician assistants under physician supervision may serve as PCPs. There may be circumstances when the specialist is the PCP (e.g., a member is designated with special health care needs).

AdSS are required to keep a current file of member PCP assignments. Each AdSS must maintain accurate tracking of PCP assignments in order to facilitate continuity of care, control use, and obtain encounter data.

The AdSS must allow the member freedom of choice of the PCPs available within its network. If the member does not select a PCP, the member will be automatically assigned to a PCP by the AdSS. The AdSS must ensure that their network of PCPs is sufficient to provide members with available and accessible service within the following time frames specified in the AdSS Operations Manual, Policy 417.

The AdSS must develop procedures to ensure that newly enrolled pregnant members are assigned to a PCP who provides obstetrical care or are referred to an obstetrician, in accordance with Division Medical Policy Manual, Policy 410 Maternity Care Services. Women may elect to use a specialist in obstetrics and/or gynecology for well woman services.

Physician Extender Visits in a Nursing Facility

Initial and any or all subsequent visits to a Division-enrolled member in a Nursing Facility (NF) or Skilled Nursing Facility (SNF), made by a physician extender, are covered services when all of the following criteria are met:

A. The physician extender is working in collaboration with a physician.
B. The physician extender is not an employee of the facility.
C. The source of payment for the NF/SNF stay is Medicaid.
For the purposes of this policy, the Division defines “physician extenders” as nurse practitioners and physician assistants working within the scope of their practice.

**Medical Resident Visits Under Specific Circumstances**

Residents providing service without the presence of a teaching physician must have completed more than six months (post graduate) of an approved residency program. Medical residents may provide low-level evaluation and management services to members in designated settings without the presence of the teaching physician.

**Referrals and Appointment for Specialty Care**

The AdSS must have adequate referral procedures in place in order to ensure appropriate availability and monitoring of health care services. Referral procedures must include:

A. Use of an AdSS-specific referral form

B. Definition of who is responsible for writing referrals, authorizing referrals, and adjudicating disputes regarding approval of a referral (referral to either a contracting or non-contracting provider)

C. Specifications addressing the timely availability of specialty referral appointments as specified in AdSS Operations Manual, Policy 417:

1. Specifications and procedures for linking specialty and other referrals to the financial management system; such as through the prior authorization process.

Refer to Division Medical Policy Manual, Policy 420, Family Planning, for family planning services information.
520 MEMBER TRANSITIONS

EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR 431.300 et seq

The Division of Developmental Disabilities (Division) and its Administrative Services Subcontractors (AdSSs) must identify and facilitate coordination of care for all members eligible for ALTCS during changes or transitions between AdSSs and changes in service areas and/or health care providers. Members with special circumstances (such as those listed below) may require additional or distinctive assistance during a period of transition. Policies or protocols is developing to address these situations. Special circumstances include members designated as having “special health care needs” and members who:

A. Have medical conditions or circumstances such as:
   1. Pregnancy (especially women who are high risk and in third trimester, or are within 30 days of their anticipated delivery date)
   2. Major organ or tissue transplantation services which are in process
   3. Chronic illness, which has placed the member in a high-risk category and/or resulted in hospitalization or placement in nursing, or other facilities, and/or
   4. Significant medical conditions (e.g., diabetes, hypertension, pain control, or orthopedics) that require ongoing specialist care and appointments

B. Are in treatment such as:
   1. Chemotherapy and/or radiation therapy
   2. Dialysis

C. Have ongoing needs such as:
   1. Durable medical equipment, including ventilators and other respiratory assistance equipment
   2. Home health services
   3. Medically necessary transportation on a scheduled basis
   4. Prescription medications
   5. Other services not indicated in the State Plan, but covered by Title XIX for Early and Periodic Screening, Diagnosis and Treatment-eligible members

D. At the time of transition, have received prior authorization or approval for:
   1. Scheduled elective surgery(ies)
   2. Procedures and/or therapies to be provided on dates after their transition,
including post-surgical follow-up visits

3. Sterilization and have a signed sterilization consent form, but are waiting for expiration of the thirty-day period

4. Appointments with a specialist located out of the AdSS service area

5. Nursing facility admission.

Notifications Required of AdSS

A. The relinquishing AdSS must provide relevant information regarding members who transition to a receiving AdSS. The ALTCS Enrollment Transition Information (ETI) (DDD-1541A) form must be sent to the Division for at least those members with special circumstances, listed in this policy, who are transitioning enrollment to another AdSS.

B. The relinquishing AdSS that fails to notify the receiving AdSS of transitioning members with special circumstances, or fails to send the completed ALTCS Enrollment Transition Information (ETI) (DDD-1541A), will be responsible for covering the member's care resulting from the lack of notification, for up to 30 days.

C. The relinquishing and receiving AdSSs must also provide protocols for the transfer of pertinent medical records, as discussed in this policy, and the timely notification of members, subcontractors or other providers, as appropriate during times of transition.

D. The receiving AdSS must provide new members with its handbook and emergency numbers as specified in contract.

E. The receiving AdSS must follow up appropriately for the needs identified on ALTCS Enrollment Transition Information (ETI) (DDD-1541A).

Transition Policies

The Division has specific policies for member transition issues including, but not limited to:

A. Transition from the Division to an acute care contractor

1. If a member is determined through Pre-Admission Screening (PAS) reassessment to no longer need long term care through ALTCS or the ALTCS-Transitional program, and the member is determined eligible for acute care enrollment, he/she will be transitioned to an acute care contractor.

2. The Division will receive a prior plan list for members that are being disenrolled. The Division uses this list to identify members needing an ALTCS Enrollment Transition Information (ETI) (DDD-1541A), completes, and forwards it and any other appropriate information to the acute care contractor.
3. The member’s Division Support Coordinator and AdSS must be involved in the transition process in order to assure that continuity and quality of care for the member is maintained.

4. The Division and the AdSS must implement protocols for the special circumstances that members transitioning from ALTCS may experience. The following protocols must be included:

   a. Conduct a comprehensive evaluation to determine the treatment and service regimen.
      i. The member must continue receiving the Division treatment and service regimen until that determination is made.
      ii. The exception is for Division services that are not covered by acute care contractors (e.g., attendant care or home delivered meals).
      iii. The evaluation must encompass each service the member is currently receiving from the Division and the AdSS.

   b. Develop an individualized treatment plan based on the member’s needs, past progress and projected outcomes, using information gathered from the comprehensive evaluation, the care plan, medical history, and information obtained from the Division Support Coordinator and the AdSS.

B. Transition of members hospitalized during an enrollment change

1. The AdSS must make provisions for the smooth transition of care for members who are hospitalized on the day of an enrollment change. The provisions must include protocols for the following:

   a. Authorization of treatment by the receiving AdSS on an individualized basis. The receiving AdSS must address contracting for continued treatment with the institution on a negotiated fee basis, as appropriate.

   b. Notification to the hospital and attending physician of the transition by the relinquishing AdSS.
      i. The relinquishing AdSS must notify the hospital and attending physician of the pending transition prior to the date of the transition and instruct the providers to contact the receiving AdSS for authorization of continued services.
      ii. If the relinquishing AdSS fails to provide notification to the hospital and the attending physician relative to the transitioning member, the relinquishing AdSS will be
responsible for coverage of services rendered to the hospitalized member for up to 30 days. This includes, but is not limited to, elective surgeries for which the relinquishing AdSS issued prior authorization.

c. Coordination with providers regarding activities relevant to concurrent review and discharge planning must be addressed by the receiving AdSS, along with the mechanism for notification regarding pending discharge.

d. Transfer of care to a physician and/or hospital affiliated with the receiving AdSS.

i. Transfers from an out-of-network provider to one of the receiving AdSS providers cannot be made if harmful to the member’s health and must be determined medically appropriate.

ii. The transfer may not be initiated without approval from the relinquishing AdSS Primary Care Provider (PCP), or the receiving AdSS Medical Director.

2. Members in critical care units, intensive care units, and neonatal intensive care units require close consultation between the attending physician and the receiving AdSS physician. If a member is admitted to an inpatient facility while still assigned to the relinquishing AdSS, and discharged after transition to the receiving AdSS, both must work together to coordinate discharge activities.

3. The relinquishing AdSS will be responsible for coordination with the receiving AdSS regarding each specific prior authorized service.

4. For members known to be transitioning, the relinquishing AdSS must not authorize hospital services such as elective surgeries scheduled less than 15 days prior to enrollment with the receiving AdSS.

5. If authorized to be provided during this time frame, the service for the transitioning member will be the financial responsibility of the AdSS who authorized the service.

C. Transition during major organ and tissue transplantation services

1. If there is a change in AdSS enrollment, both the relinquishing and receiving AdSS will be responsible for coordination of care and coverage for members awaiting major organ or tissue transplantation from the time of transplantation evaluation and determination through follow-up care after the transplantation surgery.

2. If a member changes AdSS enrollment while undergoing transplantation at
an AHCCCS-contracted transplant center, the relinquishing AdSS is responsible for contracted components or modules of the service up to and including completion of the service modules that the member is receiving at the time of the change.

3. The receiving AdSS is responsible for the remainder of the module components of the transplantation service.

4. If a member changes to a different AdSS while undergoing transplantation at a transplant center that is not an AHCCCS-contracted provider, each AdSS is responsible for its respective dates of service. If the relinquishing AdSS has negotiated a special rate, it is the responsibility of the receiving AdSS to coordinate the continuation of the special rate with the respective transplant center.

**Enrollment Changes for Members Receiving Outpatient Treatment for Significant Conditions**

A. AdSSs must have protocols for ongoing care of active and/or chronic "high risk" (e.g., outpatient chemotherapy, home dialysis) members and pregnant members during the transition period. The receiving AdSS must have protocols to address the timely transition of the member from the relinquishing PCP to the receiving PCP, in order to maintain continuity of care.

B. The receiving AdSS must address methods to continue the member's care, such as contracting on a negotiated rate basis with the member's current provider(s) and/or assisting members and providing instructions regarding their transfer to providers affiliated with the receiving AdSS.

C. Receiving AdSS are also responsible for coordinating the transition of pregnant women to maintain continuity of care. Pregnant women who transition to a new AdSS within the last trimester of their expected date of delivery must be allowed the option of continuing to receive services from their established physician and anticipated delivery site.

**Medically Necessary Transportation**

Service delivery locations may necessitate changes in transportation patterns for the transitioning member. The AdSS must have protocols for at least the following:

A. Information to new members on what, and how, medically necessary transportation can be obtained

B. Information to providers on how to order medically necessary transportation.

**Transfer and Interim Coverage of Prescription Medications**

The AdSS must address the issues of dispensing and refilling prescription medications during the transition period, and develop protocols for at least the following:
A. Relinquishing AdSS must cover the dispensation of the total prescription amount of either continuing or time-limited medications, if filled before midnight on the last day of enrollment. The relinquishing AdSS must also provide sufficient continuing medications for up to 15 days after the transition date.

B. The receiving AdSS must address prior authorization of prescription medication and refills of maintenance medication within 14 days of the member’s transition.

C. The relinquishing AdSS must provide notice to the receiving AdSS primary care provider of transitioning members who are currently taking prescription medications for medical conditions requiring ongoing use of medication, such as, but not limited to, immunosuppressant, psychotropic and cardiovascular medications, or unusually high cost medications.

Disposition of Durable Medical Equipment, Orthotics, Prosthetics and Other Medical Supplies

A. The AdSS must address the disposition of durable medical equipment (DME) and other medical equipment during a member's transition period and develop protocols for non-customized DME.

B. The relinquishing AdSS must provide transitioning members with DME for up to 15 days after the transition date or until the receiving AdSS supplies the service. The receiving AdSS must supply necessary DME within 14 days following the transition date.

C. To facilitate continuity of services, the receiving AdSS is encouraged to:
   1. Negotiate and/or contract for continued services with the member's current provider, and/or
   2. Provide instructions and assistance to new members on how to transfer to a DME provider who belongs to the new AdSS network.

D. The receiving AdSS must assess medical necessity of DME if equipment was rented by the relinquishing AdSS.

Customized DME

A. For purposes of this policy, customized DME is defined as equipment that has been altered or built to specifications unique to a member’s medical needs and which, most likely, cannot be used or reused to meet the needs of another individual.

B. Customized DME purchased for members by the relinquishing AdSS will remain with the member after the transition. The cost of the equipment is the responsibility of the relinquishing AdSS.

C. Customized DME ordered by the relinquishing AdSS but delivered after the transition to the receiving AdSS will be the financial responsibility of the relinquishing AdSS.
D. Maintenance contracts for customized DME purchased for members by a relinquishing AdSS will transfer with the member to the receiving AdSS. Contract payments due after the transition will be the responsibility of the receiving AdSS if they elect to continue the maintenance contract.

Transfer of Medical Records

A. Medical records must be forwarded when there is significant consequence to current treatment, or if requested by the receiving PCP or specialty provider. The cost of copying and transmitting of the medical record information specified in this policy will be the responsibility of the relinquishing PCP unless otherwise noted.

B. To ensure continuity of member care during the time of enrollment change, the AdSS must have the following procedures in place to ensure timely medical records transfer:

1. Procedure to be used by the relinquishing AdSS PCP to transfer member records to the receiving AdSS PCP.

2. Procedure regarding:
   a. The portions of a medical record to copy and forward to the receiving AdSS PCP
      The relinquishing PCP must transmit at least those records related to diagnostic tests and determinations, current treatment services, immunizations, hospitalizations with concurrent review data and discharge summaries, medications, current specialist services, behavioral health quarterly summaries and emergency care.
   b. A defined timeframe for the receipt of medical records by the receiving PCP (e.g., on the date of transfer, after hospital discharge, prior to transfer)
   c. Maintaining confidentiality of each member's medical records. In accordance with federal or state laws and court orders, contractors must comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements and 42 CFR 431.300 et seq.
   d. Transfer of other requested medical records, exceeding the requirements of this policy, including resolution of payment for copying and transmitting medical record data.
540 OTHER CARE COORDINATION ISSUES

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. §§ 15-765, 36-552(C), 36-558(A), 36-560(B); A.A.C. R9-28-509; and, Social Security Act § 1915(k).

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

Problem Resolution

The AdSS must establish policies that address problem resolution.

Members Presenting for Care Outside the AdSS’s Provider Network

The AdSS must establish procedures for assisting members when they present to a non-contracted provider that include, but are not limited to:

A. Identification of a specific AdSS contact person for assistance
B. Identification of a telephone number to obtain AdSS information
C. Electronic and hard copy (if requested) provider directories.

Members with Special Health Care Needs

A. Members with special health care needs includes all members eligible for the Division.
B. The AdSS must implement mechanisms to assess each member identified as having special health care needs, in order to identify any ongoing special conditions requiring treatment or regular care monitoring. The assessment mechanism must identify appropriate health care professionals.
C. The AdSS must share, with other entities providing services to that member, the results of its identification and assessment of that member’s needs.
D. For members requiring a specialized course of treatment or regular care monitoring, the AdSS must have procedures in place to allow members direct access to a specialist (e.g., through a standing referral or an approved number of visits) as appropriate for the member’s condition and identified needs.

Coordination of Urgent Response for Children Involved With DCS

When a child is removed from his/her home, to the protective custody of the Department of Child Safety (DCS), the AdSS must consider this to be an urgent behavioral health situation. Any child who has experienced a removal by DCS is at risk for negative emotional consequences and future behavioral health disorders. The urgent response process is to help identify the immediate behavioral health needs of children and address the trauma of the removal itself.

In cases where DCS notifies the AdSS within five days of physical removal of the child, the AdSS must implement the urgent response process within 72 hours from initial contact by
DCS, unless the AdSS and DCS have mutually arranged an alternative timeframe for coordinating a response based on the best interests of the child. If notification is received after the fifth day of removal, the AdSS, in collaboration with the DCS Specialist, has the discretion to initiate an urgent response or schedule the child for a regular intake appointment, depending on the specific circumstances surrounding the referral. If the DCS Specialist has initiated behavioral health services through the Arizona Department of Health Services (ADHS) Behavioral Health System, the Children’s Rehabilitative Services (CRS) Contractor may authorize continued services with the behavioral health provider that has established a treatment relationship with the child until a safe transition to a contracted behavioral health provider can be completed.

The urgent response process must include:

A. Contact the DCS Specialist to gather relevant information such as the outcome of the DCS Safety Assessment, the reason for the removal, how-when-where the removal occurred, any known special needs of the child, any known supports for the child, current disposition of siblings, any known needs of the new caregiver, etc.

B. Conduct a comprehensive assessment identifying immediate safety needs and presenting problems of the child. At this time, trauma issues such as grief and loss should be addressed. In addition, the assessment process is expected to consider an extended assessment period to more accurately identify any emerging/developing behavioral health needs that are not immediately apparent following the child’s removal.

C. Stabilization of behavioral health crises and offering of immediate services.

D. The provision of behavioral health services to the child with the intention of reducing the stress and anxiety that the child may be experiencing, and offering a coherent explanation to the child about what is happening and what can be expected to happen in the near-term.

E. The provision of needed behavioral health services to the child’s caregiver, including guidance about how to respond to the child’s immediate needs in adjusting to foster care, behavioral health symptoms to watch for and report, assistance in responding to any behavioral health symptoms the child may exhibit, and identification of a contact within the behavioral health provider network.

F. Provide the DCS Case Manager and DDD Support Coordinator with findings and recommendations for medically necessary covered behavioral health services for the initial Preliminary Protective Hearing, which occurs within five to seven days of the child’s removal.

G. If the child is placed with temporary caregivers, services should support the child’s stability by addressing the child’s behavioral health needs, identifying any risk factors for placement disruption, and anticipating crisis that might develop. Behavioral health services must proactively plan for transitions in the child’s life. Transitions may include changes in placement, educational setting, and/or reaching the age of majority.
541 COORDINATION OF CARE WITH OTHER GOVERNMENT AGENCIES

EFFECTIVE DATE: October 1, 2019


This policy applies to the Division’s Administrative Services Subcontractors (AdSS) as delineated within policy.

The AdSS is required to develop and maintain collaborative relationships with other government entities that deliver services to members and their families, ensure access to services, and coordinate care with consistent quality.

Appropriate authorizations to release information must be obtained prior to releasing information.

Definitions

A. Adult Recovery Team (ART) - A group of individuals that, following the nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, work in collaboration and are actively involved in a member's assessment, service planning, and service delivery. At a minimum, the team consists of the member's guardian/designated representative (if applicable), advocates (if assigned), and a qualified behavioral health representative. The team may also include the enrolled member's family, physical health, behavioral health or social service providers, other agencies serving the member, professionals representing various areas of expertise related to the member's needs, or other members identified by the enrolled member.

B. Child and Family Team (CFT) - A defined group of individuals that includes, at a minimum, the child and his or her family, the assigned Support Coordinator, a behavioral health representative, and any individuals important in the child’s life that are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches and community resource providers, representatives from churches, synagogues or mosques, agents from other service systems like Department of Child Safety (DCS) or the Division of Developmental Disabilities (DDD), which includes AzEIP. The size, scope and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective Planning Document, and can therefore expand and contract as necessary to be successful on behalf of the child.

C. Rapid Response - A process in which, a behavioral health service provider is dispatched within 72 hours, to assess a child’s immediate behavioral health needs, and refer for further assessments through the behavioral health system when a child first enters into DCS custody.
D. **Service Plan (Behavioral Health)** - A complete written description of all covered behavioral health services and other informal supports that includes individualized goals, family support services, care coordination activities, and strategies to assist the member in achieving an improved quality of life.

E. **State Placing Agency** - The Department of Juvenile Corrections, Department of Economic Security, Department of Child Safety, the Arizona Health Care Cost Containment System or the Administrative Office of the Court. (A.R.S. §15-1181(12)).

F. **Team Decision Making (TDM)** - When an emergency removal of a child has occurred or the removal of a child is being considered, a TDM Meeting is held. The purpose of the meeting is to discuss the child’s safety and where they will live.

**Policy**

The AdSS must develop policies, protocols, and procedures that describe how member care will be coordinated and managed with other governmental entities. The AdSS is responsible for ensuring collaboration with government agencies, including but not limited to involvement in the member’s Planning Team.

The AdSS must ensure that all required protocols and agreements with state agencies are delineated in provider manuals. AdSS must develop mechanisms and processes to identify barriers to timely services for members served by other governmental entities and work collaboratively to remove barriers to care and to resolve any quality of care concerns.

A. **Arizona Department of Child Safety (DCS)**

AdSS is required to work in collaboration with DCS as outlined below:

1. **General Requirements:**
   a. Coordinate development of the Service Plan with the DCS case plan to avoid redundancies and/or inconsistencies;
   b. Provide the DCS Specialist and the juvenile court with preliminary findings and recommendations on behavioral health risk factors, symptoms and service needs for court hearings;
   c. Ensure a behavioral health assessment is performed and identify behavioral health needs of the child, the child’s parents, and family and provide necessary behavioral health services, including support services to caregivers;
   d. As appropriate, engage the child’s parents, family, caregivers, and DCS Specialist in the behavioral health assessment and Service Planning process as members of the CFT;
e. Attend team meetings such as Team Decision Making (TDM) providing input about the child and family’s behavioral health needs. When it is possible, TDM and CFT meetings should be combined;

f. Coordinate necessary services to stabilize in-home and out-of-home placements provided by DCS;

g. Coordinate provision of behavioral health services in support of family reunification and/or other permanency plans identified by DCS;

h. Coordinate activities and service delivery that supports the child and family Plans and facilitates adherence to established timeframes (see AdSS Operations Manual Policy 417 and AHCCCS Behavioral Health System Practice Tools: Transition to Adulthood, Unique Behavioral Health Services for Needs of Children, Youth and Families involved with DCS, and Child and Family Team; and

i. Coordinate activities including coordination with the adult service providers rendering services to adult family members.

2. Rapid Response Process:

   The AdSS must consider the removal of a child from home to the protective custody of the DCS to be an urgent behavioral health situation. Any child who has experienced a removal by DCS is at risk for negative emotional consequences and future behavioral health disorders. The Rapid Response process is to help identify the immediate behavioral health needs of children and address the trauma of the removal itself.

   a. In all cases where DCS notifies the AdSS of physical removal of the child, the AdSS must implement the Rapid Response process within 72 hours from initial contact by DCS, unless the AdSS and DCS have mutually arranged an alternative timeframe for coordinating a response based on the best interests of the child.

   i. If notification is received after 72 hours of removal, the AdSS, in collaboration with the DCS Specialist, must initiate a Rapid Response. The child may also be scheduled for an initial behavioral health assessment, depending on the specific circumstances surrounding the referral. If the DCS Specialist has initiated behavioral health services, the AdSS may authorize continued services with the behavioral health provider that has established a treatment relationship with the child; and

   ii. The AdSS must assist DCS in identifying members already receiving behavioral health services.
b. The AdSS must ensure the Rapid Response process includes:

i. Contacting the DCS Specialist to gather relevant information such as the outcome of the DCS Safety Assessment, the reason for the removal, how, when, and where the removal occurred, any known medical, behavioral, or special needs of the child, any known medications, any known supports for the child, current disposition of siblings, and any known needs of the new caregiver, etc.;

ii. Conducting a comprehensive assessment identifying immediate safety needs and presenting problems of the child. At this time, trauma issues such as grief and loss should be addressed. In addition, the assessment process is expected to consider an extended assessment period to more accurately identify any emerging/developing behavioral health needs that are not immediately apparent following the child’s removal;

iii. Stabilization of behavioral health crises and offering of immediate services. The AdSS must require its Rapid Response providers to distribute the most recent Foster and Kinship Care Resources Packet to the placement during the Rapid Response visit. The Resource Packet is available on the AHCCCS website: https://www.azahcccs.gov/Members/AlreadyCovered/MemberResources/Foster;

iv. The provision of behavioral health services to the child with the intention of reducing the stress and anxiety that the child may be experiencing, and offering a coherent explanation to the child about what is happening and what can be expected to happen in the near-term;

v. The provision of needed behavioral health services to the child’s caregiver, including guidance about how to respond to the child’s immediate needs in adjusting to foster care, behavioral health symptoms to watch for and report, assistance in responding to any behavioral health symptoms the child may exhibit, and identification of contacts within the behavioral health system;

vi. Providing the DCS Specialist with findings and recommendations for medically necessary covered behavioral health services for the initial Preliminary Protective Hearing, which occurs within five to seven days of the child’s removal; and
vii. If the child is placed with temporary caregivers, services should support the child’s stability by addressing the child’s behavioral health needs, identifying any risk factors for placement disruption, and anticipating crisis that might develop. Behavioral health services must proactively plan for transitions in the child’s life. Transitions may include changes in placement, educational setting, or reaching the age of majority.


1. The AdSS must ensure that behavioral health providers coordinate with parents/families/caregivers referred through the Arizona Families F.I.R.S.T. (AFF) Program (hereafter referred to as the AFF Program) and that the providers participate in the family’s Planning Team to coordinate services for the family and temporary caregivers.

2. The AFF Program provides expedited access to substance use treatment for parents/families/caregivers referred by DCS and the ADES/Family Assistance Administration (FAA) Jobs Program. AHCCCS participates in statewide implementation of the program with DCS. The AdSS must ensure behavioral health providers coordinate the following:
   a. Accept referrals for members eligible for the Division and ALTCS and families referred through the AFF Program.
   b. Accept referrals for members eligible for the Division and ALTCS and families referred through the AFF Program and provide services, if eligible.
   c. Collaborate with DCS, the ADES/FAA Jobs Program and substance use disorder treatment providers to minimize duplication of assessments.
   d. Develop procedures for collaboration in the referral process to ensure effective service delivery through the AdSS behavioral health system. Appropriate authorizations to release information must be obtained prior to releasing information.

3. Substance use disorder treatment for families involved with DCS must be family-centered, provide for sufficient support services and must be provided in a timely manner to promote permanency for children, stability for families, to protect the health and safety of abused and/or neglected children and promote economic security for families.

C. Arizona Department of Education (ADE), Schools, or Other Local Educational Authorities
1. The AdSS are required to work in collaboration with the ADE and assist with resources and referral linkages for children with behavioral health needs. For children eligible for the Division, AHCCCS has delegated to the Division its authority as a State Placing Agency under A.R.S. § 15-1181 for children receiving special education services pursuant to A.R.S. § 15-761 et seq. This includes the authority to place a student at a Behavioral Health Inpatient Facility that provides care, safety, and treatment.

2. The AdSS must ensure that behavioral health providers collaborate with schools and help a child achieve success in school as follows:
   a. Work with the school and share information to the extent permitted by law and authorized by the child’s parent or legal guardian. Refer to Division Medical Manual Policy 550;
   b. For children who receive special education services, include information and recommendations contained in the Individualized Education Program (IEP) during the ongoing assessment and service planning process (see Division Medical Manual Policy 300). The AdSS must invite the Behavioral health providers to IEP meetings to partner in the implementation of behavioral health interventions;
   c. For children in the custody of DCS, the behavior health provider must communicate and involve the DCS Specialist with the development of the IEP;
   d. Invite teachers and other school staff to participate in the CFT if agreed to by the child and legal guardian;
   e. Understand the IEP requirements as described in the Individuals with Disabilities Education Act (IDEA) of 2004;
   f. Support accommodations for students with disabilities who qualify under Section 504 of the Rehabilitation Act of 1973; and.
   g. Ensure that transitional planning occurs prior to and after discharge of an enrolled child from any out-of-home placement.

D. Courts and Corrections

1. AdSS must collaborate and coordinate care, and ensure that behavioral health providers collaborate and coordinate care for members with behavioral health needs and for members involved with:
   a. Arizona Department of Corrections (ADOC),
   b. Arizona Department of Juvenile Corrections (ADJC),
   c. Administrative Offices of the Court (AOC), or
d. County Jails System.

2. AdSS must collaborate with courts or correctional agencies to coordinate member care as outlined in AHCCCS AMPM Policy 1020 and as follows:

   a. Work in collaboration with the appropriate staff involved with the member;

   b. Invite probation or parole representatives to participate in the development of the Service Plan and all subsequent planning meetings for the CFT and ART with the member’s/guardian’s/designated representatives’ approval;

   c. Actively consider information and recommendations contained in probation or parole case plans when developing the Service Plan; and

   d. Ensure that the behavioral health provider evaluates and participates in transition planning prior to the release of eligible members and arranges and coordinates enrolled member care upon the member’s release.
560 CRS CARE COORDINATION AND SERVICE PLAN MANAGEMENT

EFFECTIVE DATE: October 1, 2018

This policy applies to the Administrative Services Subcontractors (AdSS).

This policy establishes requirements regarding Children’s Rehabilitative Services (CRS) care coordination for ALTCS members designated as having a CRS condition and defines the process for development and management of the member’s service plan.

The AdSS is responsible for ensuring that:

• Every member has a Service Plan initiated upon notice of enrollment; and updating the Service Plan as the member’s health condition or treatment plans change.

• Care is coordinated according to the Service Plan and in cooperation with other State Agencies, AHCCCS Contractors, or Fee-For-Service (FFS) programs with which the member is enrolled, and Community Organizations.

AHCCCS identifies members who meet a qualifying condition(s) for CRS and who require active medical, surgical, or therapy treatment for medically disabling or potentially disabling conditions, as defined in A.A.C. R9-22-1303. The AHCCCS Division of Member Services (DMS) will provide information to the AdSS related to the CRS qualifying condition(s) that are identified during the determination process. DMS may also provide information received for purposes of a CRS designation regarding care, services or procedures that may have been approved or authorized by the member’s current health plan or FFS program.

Service delivery must be provided in a family-centered, coordinated and culturally competent manner in order to meet the unique physical, behavioral and holistic needs of the member.

Members with a CRS designation may receive care and specialty services from an MSIC or community based provider in independent offices that are qualified to treat the member’s condition. The AdSS must ensure availability of alternative methods for providing services such as field clinics and telemedicine in rural areas.

The AdSS must ensure the development and implementation of a Service Plan for members designated as having a CRS Condition and are responsible for coordination of the member’s health care needs and collaboration as needed with providers, communities, agencies, service systems, and members/guardians/designated representatives in development of the Service Plan.

The AdSS must ensure the Service Plan is accessible to all service providers and contains the behavioral health, physical health, and administrative information necessary to monitor a coordinated and integrated treatment plan implementation.

Definitions

A. **Active Treatment** - a current need for treatment. The treatment is identified on the member’s service plan to treat a serious and chronic physical, developmental or behavioral condition requiring medically necessary services of a type or amount beyond that generally required by members that lasts, or is expected to last one year or longer, and requires ongoing care not generally provided by a primary care provider.
provider.

B. **CRS Condition** - any of the covered medical conditions in A.A.C. R9-22-1303 which are referred to as covered conditions in A.R.S. 36-2912.

C. **Designated Representative** - parent, guardian, relative, advocate, friend, or other person, designated in writing by a member or guardian who, upon the request of the member, assists the member in protecting the member’s rights and voicing the member’s service needs. See A.A.C. R9-22-101.

D. **Field Clinic** - “clinic” consisting of single specialty health care providers who travel to health care delivery settings closer to members and their families than the Multi-Specialty Interdisciplinary Clinics (MSICs) to provide a specific set of services including evaluation, monitoring, and treatment for CRS-related conditions on a periodic basis.

E. **Multi-Specialty Interdisciplinary Clinic (MSIC)** - established facility where specialists from multiple specialties meet with members and their families for the purpose of providing interdisciplinary services to treat members.

F. **Multi-Specialty Interdisciplinary Team (MSIT)** - team of specialists from multiple specialties who meet with members and their families for the purpose of determining an interdisciplinary treatment plan.

G. **Service Plan** - complete written description of all covered health services and other informal supports which includes individualized goals, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life.

**Care Coordination**

The AdSS must establish a process to ensure coordination of care for members that includes:

A. Coordination of member health care needs through a Service Plan

B. Collaboration with members/guardians/designated representatives, other individuals identified by the member, groups, providers, organizations and agencies charged with the administration, support or delivery of services that is consistent with federal and state privacy laws

C. Service coordination and communication, designed to manage the transition of care for a member who no longer meets CRS eligibility requirements or makes the decision to transition to another Division Contractor after the age of 21 years

D. Service coordination to ensure specialty services related to a member’s CRS condition(s) care completed, as clinically appropriate prior to the member’s 21st birthday. Appropriate service delivery and care coordination must be provided regardless of the member’s CRS designation ending.

**Service Plan Development and Maintenance**

A. The AdSS is responsible for ensuring that:
• Each member designated to have a CRS Condition has a member-centric Service Plan and that the member's first provider visit occurs within 30 days of designation.

• Services are provided according to the Service Plan.

The Service Plan serves as a working document that integrates the member’s multiple treatment plans, including behavioral health, into one document in a manner and format that is easily understood by the member/guardian/designated representative, and shared with the member/guardian/designated representative upon request or as part of the Multi-Specialty Interdisciplinary Team (MSIT), Child Family Team (CFT), or Adult Recovery Team (ART) meetings. The Service Plan identifies desired outcomes, resources, priorities, concerns, personal goals, and strategies to meet the identified objectives. The Service Plan must identify the immediate and long-term healthcare needs of each newly enrolled member and must include an action plan. The AdSS is responsible for ensuring that every member has an initial Service Plan developed by the AdSS within 14 days of the notice of designation utilizing information provided by AHCCCS DMS. The Service Plan must be monitored regularly and updated when there is a change in the member’s health condition, desired outcomes, personal goals or care objectives.

B. A comprehensive Service Plan must be developed within 60 calendar days from date of the first appointment for the CRS qualifying condition and must include, but is not limited to, all the following required elements:

a. Member demographics and enrollment data

b. Medical diagnoses, past treatment, previous surgeries (if any), procedures, medications, and allergies

c. Action plan

d. The member’s current status, including present levels of functioning in physical, cognitive, social, behavioral, and educational domains

e. Barriers to treatment, such as member/guardian/designated representative’s inability to travel to an appointment

f. The member/guardian/designated representative’s strengths, resources, priorities, and concerns related to achieving mutual recommendations and caring for the family or the member

g. Services recommended to achieve the identified objectives, including provider or person responsible and timeframe requirements for meeting desired outcomes.

C. The AdSS must identify an interdisciplinary team to implement and update the Service Plan as needed.

D. The AdSS must modify and update the Service Plan when there is a change in the member’s condition or recommended services. This will occur periodically as determined necessary by the member/guardian/designated representative, or provider(s).
E. The AdSS must identify a care coordinator responsible for ensuring implementation of interventions and the dates by which the interventions must occur, and who identifies organizations and providers with whom treatment must be coordinated.

**Specialty Referral Timelines**

The AdSS must have a policy and procedure that ensures adequate access to care through scheduling of appointments as specified in ACOM Policy 417.
580  BEHAVIORAL HEALTH REFERRAL AND INTAKE PROCESS

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 8-512.01; CFR 45-164.520 (c)(1)(B)

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

This policy outlines requirements for referral and intake in order to ensure members eligible for the Division and ALTCS are able to gain prompt access to behavioral health services.

Definitions

A. Assessment - The ongoing collection and analysis of a member’s medical, psychological, psychiatric and social conditions in order to initially determine if a health disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensure that the member’s planning document is designed to meet the member’s (and family’s) current needs and long term goals.

B. Initial Evaluation (Intake) - The collection by appropriately trained staff of basic demographic information and preliminary determination of the member's needs.

C. Referral - Any oral, written, faxed, or electronic request for behavioral health services made by a member, or member’s legal guardian, a family member, an AHCCCS health plan, primary care provider, hospital, jail, court, probation and parole officer, tribal government, Indian Health Services, school, or other governmental or community agency; and for members in the legal custody of the Department of Child Safety (DCS), the out-of-home placement, in accordance with A.R.S. § 8-512.01 in accordance with AdSS Operations Manual 449.

D. SMI Determination - A determination as to whether or not a member meets the diagnostic and functional criteria established for the purpose of determining a person’s eligibility for SMI services.

Policy

A. General Requirements for Behavioral Health Services Referral and Intake

To facilitate a member’s access to behavioral health services in a timely manner, the AdSS is to ensure an effective referral and intake process is in place for behavioral health services. This process must include:

1. Engaging with the member and/or member’s legal guardian/family member
2. Communicating to potential referral sources the process for making referrals
3. Keeping information or documents collected in the referral process confidential and protected in accordance with applicable federal and state statutes, regulations and policies
4. After obtaining appropriate consents, informing the referral source as appropriate about the final disposition of the referral
5. Conducting intakes that ensure the accurate collection of all the required information and ensure that members who have difficulty communicating because of a disability or who require language services are afforded appropriate accommodations to assist them in fully expressing their needs.

6. Collecting sufficient information about the member to determine the urgency of the situation and subsequently scheduling an assessment within the required timeframes and with an appropriate provider. (For appointment standards, see AdSS Operations Manual, Policy 417.)

B. Referrals for Individuals Admitted to a Hospital

The AdSS must respond to referrals regarding individuals admitted to a hospital for psychiatric reasons. The AdSS must attempt to conduct a face-to-face intake evaluation with the individual prior to discharge from the hospital.

C. Referrals Initiated by Department of Child Safety (DCS) Pending the Removal of a Child

Upon notification from DCS that a child has been placed in DCS custody, or is at risk of disruption of placement, the AdSS must ensure that the behavioral health providers respond according to A.R.S. § 8-512.01 and AdSS Operations Manual, Policy 449. Foster caregivers and adoptive parents may call for and consent to an urgent crisis response and/or 72 hour rapid response in accordance with AdSS Operations Manual, Policy 449.

D. Sending Referrals

AdSS’ provider directories must be maintained in accordance with AdSS Operations Manual, Policies 406 and 416 and must indicate which providers are accepting referrals and conducting initial intake evaluations. Providers must promptly notify the AdSS of any changes that would impact the accuracy of the provider directory (e.g. change in telephone or fax number, no longer accepting referrals).

Referrals may be submitted in written format or provided orally. Oral referrals must be documented in writing.

E. Accepting Referrals

1. AdSS must ensure referrals are accepted for behavioral health services 24 hours a day, seven days a week.

2. Timely triage and processing of referrals must not be delayed due to missing or incomplete information.

3. When psychotropic medications are a part of a member’s treatment or have been identified as a need by the referral source, the AdSS must ensure referrals meet the time requirements as outlined in AdSS Operations Manual, Policy 417.
4. When a Serious Mental Illness (SMI) eligibility determination is being requested as part of the referral or by the member directly, the AdSS, Indian Health Service facilities, or Tribally owned or operated facilities must ensure an eligibility assessment is conducted in accordance with the Division’s Medical Policy Manual, Policy 320-P. The SMI eligibility assessment, and pending determination, must not delay behavioral health service delivery to the member, regardless of Title XIX or Title XXI eligibility as funding allows.

F. Final Dispositions

1. Within 30 days of receiving the intake evaluation, or if the member declines behavioral health services, the AdSS must ensure notification regarding the final disposition be provided to the referring individual or entity, with appropriate release of information signed by the member, as applicable including but not limited to:

   a. Designated Support Coordinator
   b. Behavioral Health Coordinator
   c. PCP
   d. Arizona Department of Child Safety and adoption subsidy
   e. Arizona Department of Corrections
   f. Arizona Department of Juvenile Corrections
   g. Administrative Offices of the Court
   h. Arizona Department of Economic Security/Rehabilitation Services Administration, and
   i. Arizona Department of Education and affiliated school districts.

2. The final disposition must include:

   a. The date the member was seen for the intake evaluation, and the name and contact information of the provider who will assume primary responsibility for the member’s behavioral health care, or
   b. If no services will be provided, the reason why. Authorization to release information will be obtained prior to communicating the final disposition to the referral sources referenced above.
G. Documenting and Tracking Referrals

The AdSS must ensure referrals for behavioral health services are tracked and include at a minimum, the following information:

1. Member name and, if available, AHCCCS identification number
2. Date of birth
3. Name and affiliation of referral source
4. Type of referral per AdSS Operations Manual, Policy 417
5. Date and time the referral was received
6. If applicable, date and location of first available appointment and, if different, date and location of actual scheduled appointment, and
7. Final disposition of the referral.

H. Intake

1. The intake process by the provider must include:
   a. Collection of member contact and insurance information
   b. Reason why the member is seeking services and information on any accommodations the member may require to effectively participate in treatment services (e.g. need for oral interpretation or sign language services, consent forms in large font)
   c. Collection of required demographic information and completion of member demographic information sheet, including the member’s primary/preferred language in accordance with the Division Technical Interface Guidelines
   d. Completion of any applicable authorizations for the release of information to other parties
   e. Dissemination of a Member Handbook to the member
   f. Review and completion of a general consent to treatment
   g. Collection of financial information, including the identification of third party payers
   h. Review and dissemination of AdSS’ Notice of Privacy Practices (NPP) and the AHCCCS Notice of Privacy Practices (NPP) in compliance with CFR 45-164.520 (c)(1)(B), and
i. Review of the member’s rights and responsibilities, including an explanation of the Title XIX member grievance and appeal process, if applicable. The member and/or the member’s legal guardian/family member, advocate, and/or person providing special assistance, may complete some of the paperwork associated with the intake evaluation, if acceptable to the member and/or the member’s legal guardian/family members, advocate, and/or person providing special assistance as referenced in the Division’s Medical Policy Manual, Policy 320-R.

2. Behavioral health providers conducting intake interviews must be appropriately trained in accordance with the Division’s Medical Policy Manual, Policy 1060, and must approach the member and family in a strength-based manner and possess a clear understanding of the information that needs to be collected.
640 ADVANCE DIRECTIVES

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 36-3231; 42 CFR 489.102; 42 U.S.C. 1396

The Administrative Services Subcontractors (AdSS) of the Division of Developmental Disabilities must ensure their providers (e.g., hospitals, nursing facilities, hospice providers, home health agencies) comply with federal and state laws regarding advance directives for members who are adults. An Advance Directive is a document by which an individual makes provision for health care decisions in the event that, in the future, the individual becomes unable to make those decisions.

A. At a minimum, providers must:
   1. Maintain written policies for members receiving care through their organization regarding the member's ability to make decisions about medical care, including the right to accept or refuse medical care and the right to execute an advance directive.
   2. Provide written information to members regarding the provider’s policies concerning advance directives, including any conscientious objections.
   3. Document in the member’s medical record whether or not the member has been provided the information, and whether an advance directive has been executed.
   4. Prevent discrimination against a member because of the member’s decision to execute or not execute an advance directive, and not place conditions on the provision of care to the member, because of the member’s decision to execute or not execute an advance directive.
   5. Provide to members, and when the member is incapacitated or unable to receive information, the member’s family or surrogate as defined in A.R.S. § 36-3231, written information regarding advance directives as delineated in 42 CFR 489.102(e), concerning:
      a. The member’s rights, regarding advance directives under Arizona State law
      b. The AdSS’s policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience
      c. A description of the applicable state law and information regarding the implementation of these rights
      d. The member’s right to file complaints directly with the Division or AHCCCS
      e. Written policies including a clear and precise statement of limitations if the provider cannot implement an advance directive as a matter of
conscience. This statement, at a minimum, should:

i. Clarify institution-wide conscientious objections and those of individual physicians

ii. Identify state legal authority permitting such objections

iii. Describe the range of medical conditions or procedures affected by the conscience objection.

B. The provider is not relieved of its obligation to provide the above information to the individual once the individual is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

C. The provider must also provide the above information to an individual upon each admission to a hospital or nursing facility and each time the individual comes under the care of a home health agency.

D. Providers must provide a copy of a member’s executed advance directive, or documentation of refusal, to the member’s Primary Care Provider for inclusion in the member’s medical record; and, provide education to staff on issues concerning advance directives.
670 FEDERALLY QUALIFIED HEALTHCARE CENTERS AND RURAL HEALTH CLINICS
REIMBURSEMENT

EFFECTIVE DATE: October 1, 2019

PURPOSE: To establish requirements for Administrative Services Subcontractors regarding reimbursement for case management, behavioral health group therapy, Telehealth and Telemedicine services for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC).

DEFINITIONS:

Behavioral Health Technician, as specified in AAC R9-10-101, an individual who is not a Behavioral Health Professional, who provides behavioral health services at or for a health care institution according to the health care institution’s policies and procedures that:

1. If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33, and
2. Are provided with clinical oversight by a behavioral health professional.

Case Management means services furnished to assist members, eligible under the State Plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services, and does not include the direct delivery of underlying medical, educational, social, or other services in accordance with 42 CFR §441.18.

Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC), for purposes of this policy, are reimbursed under the same methodology. An FQHC is a provider who is registered with AHCCCS as provider type C2 or C5. An RHC is a provider who is registered with AHCCCS as provider type 29. This Policy does not apply to any other provider or under any other circumstances.

FQHC/RHC Services, for purposes of this policy, the services of specific licensed professionals, services provided incident to those professional services, and any other ambulatory services offered by the FQHC/RHC that are otherwise included in the State Medicaid Plan.

FQHC/RHC Visit is a face-to-face encounter with a licensed AHCCCS registered practitioner during which an AHCCCS-covered ambulatory service is provided when that service is not incident to another service. Multiple encounters with more than one practitioner within the same discipline (i.e., dental, physical, behavioral health) or with the same practitioner and which take place on the same day and at a single location, constitute a single visit unless the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. In this circumstance, the subsequent encounter is considered a separate visit. A service which is provided incident to another service, whether or not on the same day or at the same location, is considered to be part of the visit and is not reimbursed.
Services “incident to” a visit means: (a) Services and supplies that are an integral, though incidental, part of the physician’s or practitioner’s professional service (e.g., medical supplies, venipuncture, assistance by auxiliary personnel such as a nurse or medical assistant); or (b) Diagnostic or therapeutic ancillary services provided on an outpatient basis as an adjunct to basic medical or surgical services (e.g., x-ray, medication, laboratory test).

**Prospective Payment System (PPS) Rate**, for purposes of this policy, an all-inclusive per visit rate for reimbursing FQHC/RHC services.

**POLICY**

**A. FQHC/RHC Reimbursement for Case Management (T1016)**

1. Case Management is not an FQHC/RHC visit reimbursable at the all-inclusive per visit PPS rate. Case Management (T1016) is reimbursed at the capped fee-for-service fee schedule when provided by a provider within their scope of practice.

2. FQHCs/RHCs are entitled to reimbursement at the all-inclusive per visit PPS rate for encounters that meet the definition of “FQHC/RHC visit.”

3. Provider Case Management is not a reimbursable service for Tribal ALTCS. This service is provided through the Tribal ALTCS Programs.

**B. FQHC/RHC Reimbursement for Behavioral Health Technician Provided Services**

Excluding case management, the services of a BHT may qualify as a FQHC/RHC visit only when those services meet the requirements of 42 CFR Part 405, Subpart X.

**C. Behavioral Health Group Therapy/Group Services**

Behavioral health group therapy and/or any other services provided to a group do not satisfy the requirements of a face-to-face encounter; therefore, these services are not reimbursable at the all-inclusive per visit PPS rate.

**D. Telehealth and Telemedicine for FQHC/RHC Service**

Telehealth and Telemedicine may qualify as a FQHC/RHC visit if it meets the requirements as specified in AdSS Medical Policy 320-I.

For additional information regarding FQHC/RHC reimbursement, refer to AHCCCS Fee- For-Service Provider Manual, Chapter 10 addendum. For Provider Type C5, refer to AHCCCS IHS/Tribal Provider Billing Manual Chapter 20.
680-C PRE-ADMISSION SCREENING AND RESIDENT REVIEW

EFFECTIVE DATE: October 1, 2019
REFERENCES: CFR 42-483.100-483.138, 42-483.112(c), 42-483.112 (c-2), 42-483.12 (a) 1-7, 42-431 (E), and, 42-447.

Federal nursing home reform legislation enacted through the 1987 Omnibus Reconciliation Act (OBRA) established the Pre-Admission Screening and Resident Review (PASRR) Program. The PASRR regulations mandate that all members entering a Title XIX (Medicaid) certified nursing facility be screened for a cognitive/intellectual disability or a related diagnosis and/or mental illness to avoid inappropriate placement. In addition, the OBRA specifies that placement for members with a cognitive/intellectual disability or mental illness are made based on their needs for nursing facility services and for specialized services.

State Medicaid agencies are required to develop a two-stage identification and evaluation process, which accomplishes the following:

A. **PASRR Level I** – Identification of potential cognitive/intellectual disability or mental illness - Determines whether the member has any diagnosis or other presenting evidence that suggests the potential of a cognitive/intellectual disability or mental illness.

B. **PASRR Level II (Determination)** – Determines whether the member does indeed have a cognitive/intellectual disability or mental illness. If the member has been determined to have a cognitive/intellectual disability or mental illness, this stage of the evaluation process determines whether the member requires the level of services provided by a nursing facility and/or specialized services.

**Service Description**

The procedures described in this section will apply to all members seeking admission of a 30-day or longer stay in a Title XIX or Medicaid certified nursing facility.

**State Agreement Requirements**

Referrals for a PASRR Level II determination of cognitive/intellectual disability are handled by the Arizona Department of Economic Security (DES) through the Division of Developmental Disabilities (DDD). Interagency agreements between the Arizona Health Care Cost Containment System (AHCCCS) Administration and the Division have been established to develop and maintain the Level II process to determine whether each member referred by primary care providers, nursing facilities or the AHCCCS/Arizona Long Term Care System (ALTCS) Administration (Pre-Admission Screening Assessors) requires the level of services provided by a nursing facility and/or specialized services for a cognitive/intellectual disability.

**Cognitive/intellectual disability**

Developmental disability is defined as a chronic disability which is attributable to a cognitive/intellectual disability, cerebral palsy, epilepsy, autism, and any related condition. The disability results in the impairment of general intellectual functioning or adaptive behavior and requires medical treatment or services. The impairment must be manifested before the age of 22. The impairment must be likely to continue indefinitely and result in substantial functional limitations in major life activities. When determined by a medical
professional the range of intellectual functioning (mild, moderate, severe, or profound) will be documented on the PASRR Level II Evaluation.

**Specialized Services (as pertaining to cognitive/intellectual disability)**

The services specified by the cognitive/intellectual disability authority which, when combined with services provided by the nursing facility or other service providers, result in treatment which includes aggressive, consistent implementation of a program of specialized, and/or generic services, and related services that are directed toward the following:

A. The acquisition of behaviors necessary for the member to function with as much self-determination and independence as possible; and

B. The prevention or deceleration of regression or loss of current optimal functional status.

If there are indications of a cognitive/intellectual disability or a related diagnosis, the completed PASRR Level I and all supporting documentation should be forwarded to the Division. Supporting documentation may include the Minimum Data Set (MDS), health and progress notes, assessments, or other documentation by a medical professional that suggests the presence of a cognitive/intellectual disability. Specialized services include aggressive, consistent implementation of a program of specialized and/or generic services, and related services that are directed toward the acquisition of behaviors necessary for the member to function with as much self-determination and independence as possible, and the prevention or declaration of regression or loss of current optimal functional status.

The PASRR Level I is reviewed by the PASRR Coordinator who then determines if a Level II is necessary. If so:

A. The PASRR Coordinator will contact the facility and speak to the referring member to confirm the current placement and that the medical files for the resident will be reviewed.

B. The MDS in the member’s file will also be reviewed for information concerning the member’s functioning level and medical problems. The information gathered from the MDS and the member’s resident’s medical files will assist in completing the Level II. PASRR Level II determinations must be completed within an average of seven to nine working days of receipt of referral.

**IF THE MEMBER IS AWAITING DISCHARGE FROM A HOSPITAL, THE LEVEL II WILL BE COMPLETED AS SOON AS POSSIBLE, AND IF NECESSARY BEFORE THE FEDERALLY MANDATED SEVEN TO NINE WORKING DAYS TIMEFRAME.**

**Pre-Admission Screening And Resident Review Determination**

The PASRR Level II evaluation instrument and necessary procedures developed by the Division gather pertinent information needed to determine and recommend appropriate levels of care and services and when applicable in the least restrictive environment that could continue to provide the needed medical treatment. The criteria used in making a decision about appropriate placement will not be affected by the availability of placement alternatives.
Evaluation Requirements

PASRR reviews will be adapted to the member’s cultural background, language, ethnic origin, and means of communication. Current and relevant assessment information obtained prior to the initiation of the PASRR process may be used. Findings must be accurate and correspond to the members’ current functional level and must be descriptive.

The Division may convey the determinations verbally to the referring agency and the member and then confirm them in writing in accordance with 42 CFR 483.112 (c-2).

Copies of the completed PASRR Level II are forwarded to the referring agency, facility, AHCCCS and if dually diagnosed (cognitive/intellectual disability and mental illness) to Arizona Department of Health Services, the primary care physician and the member and/or representative, with a notice of the member’s right to appeal the determinations.

The Division is responsible for ensuring that appropriate level of care and medical services are provided to those members who have been diagnosed prior to their 22nd birthday to have a cognitive/intellectual disability or a related diagnosis.

The Division’s PASRR Coordinator is responsible for interpretation of the PASRR findings to the person or designated family member and/or representative if the applicant for admission or resident is incapable of understanding the PASRR findings.

ANNUAL REVIEWS ARE NOW REVISED REVIEWS AND WILL BE CONDUCTED WHEN: A significant change has occurred in the member’s physical or mental condition. It is a federal requirement for a nursing facility to notify the state authority promptly when and if a significant change has occurred utilizing the Minimum Data Sets (MDS) guidelines for significant change requirements to ensure that all members with a cognitive/intellectual disability or related diagnosis continue to require nursing facility services and or specialized services. The Division’s PASRR Coordinator also will search the data base every month and contact the facility to inquire if any significant changes have occurred to warrant a revised PASRR Level II. If no change has occurred, a letter is sent to confirm the conversation and is placed in the resident's file. If a significant change has occurred, pertinent information is gathered again, and the resident is scheduled for a Revised Review.

A REVISED PASRR LEVEL II IS NOT NEEDED FOR RE-ADMISSIONS FROM THE HOSPITAL OR INTER-FACILITY TRANSFERS.

Cease Process and Documentation Situation

If, at any time during this process it is found that the member does not have a cognitive/intellectual disability or related diagnosis or has a principal/primary diagnosis of Dementia, Alzheimer’s Disease, or any related disorder or has any condition identified in section B of the PASRR Level I, that situation will be documented and the process will be stopped. If the illness results in a level of impairment so severe the member could not be expected to benefit from specialized services the process will be stopped.

THE DIVISION WILL RE-ASSESS THE MEMBER WHEN NOTIFIED BY THE NURSING FACILITY OF AN IMPROVEMENT IN HIS/HER CONDITION.

Nursing Facility Level of Care Inappropriate

The nursing facility in accordance with the state authority must provide or arrange for the
safe and orderly discharge of the resident in accordance with 42 CFR 483.12 (a) 1-7, the member shall be prepared and oriented for discharge.

Any members who are currently enrolled with the Division of Developmental Disabilities Division who have been found to be unsuitable for a Skilled Nursing Facility should be informed of less restrictive placement options and when in agreement, discharged to a less restrictive setting. Their Support Coordinator must ensure that the Member Support Plan process is followed, including participation by the member or responsible representative, primary care physician, nursing facility staff, District discharge planning team and other relevant members.

**Appeal Mechanism**

The Division will ensure that the person or their designee is informed of the appeals process available to them: appeal of determination for members who are adversely affected (members for whom the screening process indicated that admission to nursing facility would not be appropriate) the appeals process must follow the guidelines contained in 42 CFR 431 Subpart E. The Division will also recommend appropriate placement alternatives.

**Referral Designation**

The Division will maintain case records for all Level II evaluations for a period of five years in accordance with 42 CFR parts 447.
900 CHAPTER DELIVERABLES

Deliverables specific to individual Policies are identified in those individual Policies.

Deliverables related to this Chapter as a whole include:

1. Actions Reported to the NPDB (National Provider Databank) or a Regulatory Board
2. Adverse Action Reporting (Including Limitations and Terminations)
3. Health Care Acquired Conditions (HCAC) and Other Provider-Preventable Condition (OPPC)
4. Quality Management/Performance Improvement (QM/PI) Program Annual Plan
5. Quality Management (QM) Report
910 QUALITY MANAGEMENT/PERFORMANCE IMPROVEMENT PROGRAM
ADMINISTRATIVE REQUIREMENTS

EFFECTIVE DATE: October 1, 2019

REFERENCES: 42 CFR 438.242 et seq.; AMPM Policy 910; AMPM Exhibits 400-2A, 2B, 2C, and 910-1; Section F3, Contractor Chart of Deliverables

DELIVERABLES: Integrated Health Care Report

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

Quality Management/Performance Improvement Plan

A. The Administrative Services Subcontractors (AdSS) must develop a written Quality Management/Performance Improvement (QM/PI) Plan, as specified in Section F3, Contractor Chart of Deliverables, that addresses the proposed methodology to meet or exceed the standards and requirements in the contract and this chapter.

B. The QM/PI Plan must describe how program activities will improve the quality of care, service delivery, and satisfaction for Arizona Long Term Care System (ALTCS)-eligible members.

C. The QM/PI Plan, and any subsequent modifications must be submitted to the Division Quality Management Unit for review and approval prior to implementation.

D. The QM/PI Plan must include, at a minimum, in paginated detail, the following components:

1. QM/PI Program Administrative Oversight

The AdSS’s QM/PI Program must be administered through a clear and appropriate administrative structure. The governing or policymaking body must oversee and be accountable for the QM/PI Program. The AdSS must provide:

   a. A description to ensure ongoing communication and collaboration between the QM/PI Program and the other functional areas of the organization (e.g., Medical Management, Member Services, Behavioral Health, Provider Relations, Grievance and Appeals, Fraud, Waste, and Abuse)

   b. A description of the AdSS’s administrative structure for oversight of its QM/PI Program as required by this policy, which includes the role and responsibilities of:

      i. The governing or policy making body
      ii. The Medical Director
      iii. The QM/PI Committee
      iv. The Peer Review Committee
v. The Credentialing Committee

vi. The AdSS’s Executive Management

vii. QM/PI Program Staff

c. An organizational chart which shows the reporting relationships for QM/PI activities and the percent of time dedicated to the position for each line of business

This chart must also show direct oversight of QM/PI activities by the local Medical Director and the implemented process for reporting to Executive Management.

d. Documentation that the Board of Directors and in the absence of a Board the executive body has reviewed and approved the Plan

e. Documentation that the Board of Directors and in the absence of a Board the executive body has formally evaluated and documented the effectiveness of its QM/PI program strategy and activities, at least annually.

2. QM/PI Committee

The AdSS must have an identifiable and structured local (Arizona) QM/PI Committee that is responsible for QM/PI functions and responsibilities.

a. At a minimum, the membership must include:

i. The local Medical Director as the chairperson of the Committee

The local Medical Director may designate the local Associate Medical Director as their designee only when the Medical Director is unable to attend the meeting. The local Chief Executive Officer may be identified as the co-Chair of the QM/PI Committee.

ii. The QM/PI Manager

iii. Representation from the functional areas within the organization

iv. AdSS staff with experience with Developmental Disabilities, Behavior Health, and medically fragile physical health conditions.

v. Representation of contracted or affiliated providers serving members eligible for the Division

vi. Appropriate clinical representatives.
b. The local Medical Director is responsible for implementation of the QM/PI Plan and must have substantial involvement in the implementation, assessment, and resulting improvement of the QM/PI activities.

c. The QM/PI Committee must ensure that each of its members is aware of the requirements related to confidentiality and conflicts of interest by having signed statements on file and/or QM/PI Committee sign-in sheets with requirements noted.

d. The QM/PI Committee must meet, at a minimum, quarterly or more frequently. The frequency of committee meetings must be sufficient to monitor all program requirements and to monitor any required actions.

e. The QM/PI Committee must review the QM/PI Program objectives, policies and procedures as specified in contract and must modify or update the policies when processes/activities are changed substantially. The QM/PI policies and procedures, and any subsequent modification to them, must be available upon request for review by the Division.

f. The QM/PI Committee must develop procedures for QM/PI responsibilities and clearly document the processes for each QM/PI function and activity.

g. The QM/PI Committee must develop and implement procedures to ensure the AdSS staff and providers are informed of the most current QM/PI requirements, policies and procedures.

h. The QM/PI Committee must develop and implement procedures to ensure the providers are informed of information related to their performance (e.g., Performance Measures, profiling data, medical record review results, utilization data).

i. If deficiencies are noted, the QM/PI Committee meeting minutes must clearly document discussions of the following:

   i. Identified issues

   ii. Responsible party for interventions or activities

   iii. Proposed actions

   iv. Evaluation of the actions taken

   v. Timelines including start and end dates

   vi. Additional recommendations or acceptance of the results as applicable.
3. Peer Review

The AdSS must have a peer review process with the purpose of improving the quality of medical care provided to members by providers, both individual and organizational providers. The peer review scope includes cases where there is evidence of deficient quality, or the omission of the care or service provided by a participating, or non-participating health care professional or provider whether delivered in or out of state. Peer review must be defined by specific policies and procedures that must include the following:

a. The AdSS must not delegate functions of peer review to other entities.

b. The Peer Review Committee must be scheduled to meet at least quarterly.

c. Peer review activities may be carried out as a stand-alone committee or in an executive session of the AdSS’s Quality Management Committee.

d. At a minimum, the Peer Review Committee must consist of:
   i. The AdSS’s local Chief Medical Officer as Chair
   ii. AdSS medical providers, from the community, that serve members eligible for the Division. The peer review process must ensure that providers of the same of similar specialty participate in review and recommendation of individual peer review cases. If the specialty being reviewed is not represented on the AdSS’s Peer Review Committee, the AdSS may utilize peers of the same or similar specialty through external consultation.
   iii. A Behavioral Health provider must be part of the Peer Review Committee when a behavioral health case is being reviewed.

e. Peer Review Committee members must sign (may be an electronic signature) a confidentiality and conflict of interest statement at each Peer Review Committee meeting. Committee members must not participate in peer review activities if they have a direct or indirect interest in the peer review outcome.

f. The Peer Review Committee must evaluate the case referred to peer review based on all information made available through the quality management process.

g. The Peer Review Committee is responsible for making recommendations to the AdSS’s Medical Director. The Peer Review Committee must determine appropriate action (e.g., peer contact, education, credentials, limit on new member enrollment, sanctions) and other corrective actions. Adverse actions taken as a result of the Peer Review Committee must be reported to the Division within 24
hours of an adverse decision being made.

h. The Peer Review Committee is responsible for making appropriate recommendation for the AdSS’s Medical Director to make referrals to the Department of Child Safety, Adult Protective Services, and the Department of Health Services Licensure Unit, the appropriate regulatory agency or board, and the Division, for further investigation or action. Notification must occur when the Peer Review Committee determines care was not provided according to the medical community standards. Initial notification may be verbal but must be followed by a written report to the Division within 24 hours.

i. Peer Review Committee policies and procedures must assure that all information used in the peer review process is kept confidential and is not discussed outside of the peer review process. The AdSS’s Peer Review Committee reports, meetings, minutes, documents, recommendations, and participants must be kept confidential except for implementing recommendation made by the Peer Review Committee.

j. The AdSS must make peer review documentation available to the Division for purposes of quality management, monitoring, and oversight.

k. The AdSS must demonstrate how the peer review process is used to analyze and address clinical issues.

l. The AdSS must demonstrate how providers are made aware of the peer review process and peer review grievance procedure.

m. Matters appropriate for peer review may include, but are not limited to:

i. Cases where there is evidence of deficient quality

ii. An omission of the care or service provided by a participating or non-participating physical health care or behavioral health care provider

iii. Questionable clinical decisions, lack of care and/or substandard care

iv. Inappropriate interpersonal interactions or unethical behavior, physical, psychological, or verbal abuse of a member, family, staff, or other disruptive behavior

v. Allegations of criminal or felonious actions related to practice

vi. Issues that immediately impact the member and that are life threatening or dangerous
vii. Unanticipated death of a member; issues that have the potential for adverse outcome

viii. Allegations from any source that bring into question the standard of practice.

4. QM/PI Staffing

The QM/PI Program must have qualified local personnel to carry out the functions and responsibilities specified in this Chapter in a timely and competent manner. The AdSS is responsible for contract performance whether or not subcontractors or delegated entities are used. Policies and procedures must demonstrate:

a. Staff qualifications including education, certifications, experience and training for each QM/PI position

b. A current organizational chart that demonstrates the reporting structure, responsibilities, number of full time and part time positions, and their percent of time by line of business for the QM/PI Program

c. The AdSS’s Quality Management Coordinator must attend Division contractor meetings unless attendance is specified as optional by the Division.

d. The AdSS must participate in applicable community initiatives, such as, but not limited to:

i. Quality Management and quality improvement

ii. Maternal child health

iii. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

iv. Disease management

v. Behavioral health

vi. The Division may require AdSS participation in specific community initiatives and collaborations

e. The AdSS must develop a process to ensure that all staff who may have contact with members or providers are trained on how to refer suspected quality of care issues to the Quality Management Unit. This training must be provided during employee orientation and, at a minimum annually thereafter.
5. **Delegated Entities**

The AdSS must oversee and maintain accountability for all functions and responsibilities described in this Chapter that are delegated to other entities. The AdSS must include a description of how delegated activities are integrated into the overall QM/PI Program and the methodologies for oversight and accountability of all delegated functions. Accredited agencies must be included in the AdSS’ oversight process.

a. As a prerequisite to delegation, the AdSS must provide a written analysis of its historical provisions of QM/PI oversight function which includes past goals and objectives. The level of effectiveness of the prior QM/PI oversight functions must be documented. Examples may include the number of claims, concerns, grievances or network gaps.

b. The AdSS must have policies and procedures requiring the delegated entity report to the AdSS all allegations of quality of care and quality of service issues. Quality of care or service investigation and resolution processes may not be delegated.

i. The AdSS must evaluate the entity’s ability to perform the delegated activities prior to delegation, evidence of which includes the following: Review of appropriate internal areas, such as quality management

ii. Review of policies and procedures and the implementation of them

iii. Documented evaluation and determination that the entity is able to effectively perform the delegated activities.

c. Prior to delegation, a written contract must be established that specifies the delegated activities and reporting responsibilities of the entity to the AdSS. The agreement must include the AdSS’s right to ruminant the contract or perform other remedies for inadequate performance.

d. The performance of the entity and the quality of services provided are monitored on an ongoing basis and are annually reviewed by the AdSS. Annually, the AdSS must review a minimum of 30 randomly selected files per line of business for each function that is delegated. Documentation must be kept on file for review by the Division. Monitoring should include, but is not limited to:

i. Utilization

ii. Member and provider satisfaction

iii. Quality of care concerns

iv. Complaints.
e. The following documentation must be kept on file and available for Division review:

i. Evaluation reports

ii. Results of the AdSS’s annual monitoring review of the delegated entity utilizing Division required standards for the contracted functions

iii. Corrective Action Plans

iv. Appropriate follow up of the implementation of corrective action plans to ensure quality and compliance with Division requirements for all delegated activities or functions are met.

6. Chapter 900 Requirements

The AdSS must have policies and procedures to describe the implementation of the following:

a. The AdSS’s method(s) for monitoring and evaluating its service delivery system and provider network that demonstrates compliance with Division Medical Policy 920

b. How members’ rights and responsibilities are defined, implemented, and monitored to meet requirements of Policy 930 of Chapter

c. Documentation that the AdSS has implemented policies and procedures in compliance with Division Medical Policy 940 to ensure medical records and communication of clinical information for each member reflect all aspects of member care, including ancillary and behavioral health services. Policies must include processes for digital (electronic) signatures when electronic documents are used.

d. The AdSS’s temporary/provisional credentialing, initial credentialing and re-credentialing process for individual providers and assessment and reassessment of organizational providers contracted with the AdSS, as required by Division Medical Policy 950.

e. The AdSS’s process for grievance resolution, tracking and trending that meet standards set in Division Medical Policy 960 of this Chapter and 42 CFR 438.242 et seq.

f. Documentation of the AdSS’s planned activities to meet or exceed Division mandated performance measures minimum performance standards and performance improvement project goals as specified in contract and required by Division Medical Policies 970 and 980.

g. Indication or documentation of input from contracted or affiliated providers.
h. Indication or documentation of input from members eligible for the Division.

i. How the AdSS monitors the quality and coordination of behavioral health services. The description must include procedures used to ensure timely updates from primary care providers to behavioral health providers regarding a member’s change in health status. The update must include but is not limited to diagnosis of chronic conditions, all medication prescribed, and any other information pertinent to the continuing care of the member.

j. The comprehensive and coordinated delivery of integrated services including administrative and clinical integration of health service delivery. Integration strategies and activities must focus on improving individual health outcomes, enhancing care coordination and increasing member satisfaction.

7. Health Information System Policies and Procedures

The AdSS must maintain a health information system that collects, integrates, analyzes, validates and reports data necessary to implement its QM/PI Program (42 CFR 438.242). the AdSS must include a description of the process used by the AdSS related to the health information system and how the system is used to collect, integrate, analyze, validate, and report data necessary to implement the QM/PI program. Data elements must include:

a. Member demographics
b. Provider characteristics
c. Services provided to members
d. Other information necessary to guide the selection of, and meet the data collection requirements for PIPs and QM/PI oversight.

8. Policies and Procedures

The AdSS must have written policies and procedures, by line of business, to ensure that:

a. Information/data received from providers is accurate, timely, and complete
b. Reported data is reviewed for accuracy, completeness, logic and consistency, and the review and evaluation processes used are clearly documented
c. Information rejected must be tracked to ensure errors are corrected and the data is resubmitted and accepted
d. All member and provider information protected by federal and state
law, regulations, or policies is kept confidential

e. Contractor staff and providers are kept informed of at least the following:
   i. QM/PI requirements, activities, updates or revisions
   ii. Study and Performance Improvement Project (PIP) results
   iii. Performance measures and results
   iv. Utilization data
   v. Profiling results.

Annual Work Plan

A. The annual work plan is a work plan by line of business that includes all requirements of Division Medical Policy 920 and guidelines suggested by the Division, and supports the AdSS’s QM/PI goals and objectives. The AdSS must develop and implement a work plan with timelines that includes, but is not limited to, the following information:

1. A description of all planned goals and objectives for both clinical care and AdSS monitoring of access and availability of covered services

   Once a goal has been achieved and sustained, the AdSS must identify new goals based on data, member/provider input, etc.

2. Targeted implementation and completion dates of work plan activities

3. Methodologies, strategies and specific measurable interventions to accomplish objectives

4. Measurable behavioral health goals and objectives

5. Assigned local staff positions responsible and accountable for meeting established goals and objectives.

B. The AdSS must review its work plan at least quarterly. If activities and interventions are not meeting the goals and objectives, the contractor must revise its work plan and develop new strategies aimed at achieving the goals.

QM/PI Program Evaluation

The annual QM/PI evaluation document must contain a summary of all QM/PI activities performed throughout the year and the following:

A. Title/name of each activity

B. Measurable goals and/or objective(s) related to each activity
C. AdSS departments or units and local staff positions involved in the QM/PI activities

D. Description of communication and feedback related to QM/PI data and activities

E. An evaluation of baseline data and outcomes utilizing qualitative and quantitative data which must include a statement describing if goals/objectives were met or not met

F. A description of how the sustained goal/objective is incorporated into the AdSS’s business practice (institutionalized)

   The AdSS is expected to develop new goals and objectives once a goal or objective has been sustained.

G. Actions to be taken for the improvement of Corrective Action Plan (CAP)

H. Documentation of continued monitoring to evaluate the effectiveness of the actions (interventions) and other follow up activities

I. Rationale for changes in the scope of the QM/PI program or documentation indicating if no changes were made

J. Necessary follow-up with targeted timelines for revisions made to the QM/PI Plan

K. Documentation of the QM/PI Committee review, evaluation, and approval of any changes to the QM/PI Plan

L. An evaluation of the previous year’s activities must be submitted as part of the QM/PI Plan after review by the AdSS’s governing or policy making body.

**QM/PI Plan and Evaluation**

See Section F3, Contractor Chart of Deliverables, for reporting timelines. For submission to the Division, the following by line of business, may be combined or written separately and paginated as long as required components are addressed and are easily located within the document(s) submitted:

A. QM/PI Plan

B. QM/PI Work Plan

C. QM/PI Evaluation

D. Maternity Care Plan and associated work plans and evaluations as described in the AHCCCS Medical Policy Manual (AMPM) Chapter 400, Exhibit 400-2A, as adopted by the Division

E. EPSDT Plan and associated work plans and evaluations as described in the AMPM Chapter 400, Exhibit 400-2B, as adopted by the Division

F. Oral Health Plan and associated work plans and evaluations as described in the AMPM Chapter 400, Exhibit 400-2C, as adopted by the Division
G. PIP Interim Report(s)

H. Quality Management Plan Checklist (AMPM, Exhibit 910-1, as adopted by the Division)

I. Submission of all referenced policies and procedures to implement the requirements of this Chapter.

**QM/PI Documentation**

The AdSS must maintain records that document Quality Management and Performance Improvement (QM/PI) activities. The data must be made available to the Division upon request. The required documentation must include, but is not limited to:

A. Policies and procedures

B. Studies and Performance Improvement Plans

C. Reports

D. Processes/desktop procedures

E. Standards

F. Worksheets

G. Meeting minutes

H. Corrective Action Plans (CAPs)

I. Other information and data appropriate to support changes made to the scope of the QM/PI Plan or Program.
920 QUALITY MANAGEMENT/PERFORMANCE IMPROVEMENT (QM/PI) PROGRAM SCOPE

EFFECTIVE DATE: October 1, 2019
REFERENCES: Division Medical Policy Manual 1600; Division contract, Division Medical Policy Manual 910; 42 CFR 438.208
DELIVERABLES: Service and Service Site Monitoring

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

QM/PI Program Components

The Quality Management/Performance Improvement (QM/PI) Program components must include:

A. A detailed, written set of specific measurable objectives that demonstrates how the QM/PI Program of the Administrative Services Subcontractor meets established goals and complies with all components of Chapter 900 of this Medical Policy Manual

B. A work plan, with timelines to support the objectives, that includes:
   1. A description of all planned goals and objectives for both clinical care and other covered services
   2. Targeted implementation and completion dates for quality management measurable objectives, activities, and performance improvement projects
   3. Methodologies and activities to accomplish measurable goals and objectives
   4. Measurable behavioral health goals and objectives
   5. Staff positions responsible and accountable for established goals and objectives
   6. Detailed policies and procedures implementing all components and requirements of this Chapter

C. A new-member health risk assessment or a “best effort” attempt to conduct an initial health risk assessment that includes follow up on unsuccessful attempts to contact a member within 90 days of the effective date of enrollment

   Note: Each attempt must be documented. The AdSS must develop processes to use the results of health assessments to identify individuals at risk for and/or with special health care needs and to coordinate care (42 CFR 438.208).

D. Requirements to ensure continuity of care and integration of services through:
   1. Policies and procedures allowing each member to have a choice to select, or the AdSS to assign, a Primary Care Provider (PCP) who is formally designated as having primary responsibility for coordinating the member’s overall health care, including coordination with the behavioral health medical professional
2. Policies and procedures specifying the circumstances under which services are coordinated by the AdSS, the methods for coordination, and specific documentation of these processes

3. Programs for care coordination of covered services with community and social services, generally available through contracted or non-contracted providers, in the AdSS’s service area

4. Policies and procedures specifying services coordinated by the AdSS’s Disease Management Unit

5. Policies and procedures for timely and confidential communication of clinical information amongst providers, as specified in Policy 940 of this Chapter

6. Development and implementation of procedures for members with special health care needs, as defined in the contract, for:
   a. Identifying members with special health care needs, including those who would benefit from disease management
   b. Ensuring an assessment by an appropriate health care professional of ongoing needs of each member identified as having special health care need(s) or condition(s)
   c. Identifying medical procedures (and/or behavioral health services, as applicable) to address and/or monitor the need(s) or condition(s)
   d. Ensuring adequate care coordination among providers, including but not limited to, other contractors/insurers and behavioral health providers, as necessary
   e. Ensuring a mechanism to allow direct access to a specialist as appropriate for the member’s condition and identified special health care needs (e.g., a standing referral or an approved number of visits)

E. Implementation of measures to ensure members:
   1. Are informed of specific health care needs that require follow-up
   2. Receive training in self-care and other measures they may take to promote their own health, as appropriate
   3. Are informed of their responsibility to comply with ordered treatments or regimens

F. Maintenance of records and documentation as required under state and federal law.
QM/PI Program Monitoring and Evaluation Activities

The QM/PI Program scope of monitoring and evaluation must be comprehensive, incorporating the activities used by the AdSS, and it must demonstrate how these activities will improve the quality of services and the continuum of care in all services sites. These activities must be clearly documented in policies and procedures. The AdSS must:

A. Use information and data gleaned from QM monitoring and evaluation that shows trends in quality of care issues developing PI projects.
   
   Selection of specific monitoring and evaluation activities must be appropriate to each specific service or site.

B. Implement policies and procedures that require the individual and organizational providers to report to the proper authorities, as well as to the AdSS, incidents of abuse, neglect, injuries (e.g., falls and fractures), exploitation, healthcare acquired conditions, and or unexpected death as soon as the providers are aware of the incident.

C. Report all incidents of abuse, neglect, exploitation, and unexpected deaths to the Division’s Quality Management Unit as soon as the AdSS is aware of the incident.

   The AdSS must investigate and report case findings, including identification of organizational providers, individual providers, paid caregivers, or the specific individual rendering the service.

D. Report identified quality of care reportable incidents and/or service trends to the Division’s Clinical Quality Management Unit immediately upon identification of the trend; this reporting must include trend specifications such as providers, facilities, services, and allegation types.

E. Report Health Care Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC) to the Division’s Quality Management Unit through the Division’s Compliance Unit, using the template adopted by the Division in AHCCCS Medical Policy Manual, Exhibit 920-1.

   The AdSS must:

   1. Investigate and maintain case files that contain findings.

   2. Incorporate the ADHS licensure and certification reports and other publicly reported data in its monitoring process, as applicable.

F. Incorporate the AdSS quality of care trend reports into monitoring and evaluation activities. Policies and procedures must be adopted to explain how the process is routinely completed.
G. Ensure health and safety of members in placement settings or service sites that are found to have survey deficiencies that may impact the health and safety of members.

The AdSS must actively participate in individual and coordinated efforts to improve the quality of care in:

1. Placement settings, or service sites, that have been identified through the Licensure Survey process or other mechanisms as having an Immediate Jeopardy situation or has had more than one survey or complaint investigation resulting in a finding of non-compliance with licensure requirements.

2. Facilities placement settings or service sites that have been identified by the Division as an Immediate Care Need.

Based on findings, the AdSS must:

1. Actively participate in meetings focused on ensuring health and safety of members.

2. Actively participate in meetings scheduled to develop work plans and Corrective Action Plans (CAPs) to ensure placement setting or service sites compliance with ADHS Licensure and/or Division or AHCCCS requirements.

3. Participate in scheduled and unscheduled monitoring of placement setting or service sites that are in an Immediate Jeopardy status or have serious identified deficiencies that may affect health and safety of members (Immediate Care Needs).

4. Assist in the identification of technical assistance resources focused on achieving and sustaining licensure compliance.

5. Monitor placement setting or service sites upon completion of the activities and interventions, to ensure that compliance is sustained.

H. At a minimum annually, AdSS Quality Management staff monitor services and services sites that include, but are not limited to, the following:
**SERVICES**

Behavioral Health Therapeutic Home Care Services

Behavioral Management

Behavioral Health Personal Assistance

Family Support

Peer Support

Case Management Services

Emergency/Crisis Behavioral Health Services

Emergency Transportation

Evaluation and Screening (initial and ongoing assessment)

Group Therapy and Counseling

Individual Therapy and Counseling

Family Therapy and Counseling

Marriage/Family Counseling

Substance Use Treatment

Inpatient Hospital

Inpatient Psychiatric Facilities (resident treatment centers and sub-acute facilities)

Institutions for Mental Diseases

Laboratory and Radiology Services

Non-emergency Transportation

Nursing

Opioid Agonist Treatment

**SERVICE SITES**

Behavioral Health Outpatient Clinics

Behavioral Health Therapeutic Home (Adults and Children)

Independent Clinic

Federally Qualified Health Center

Community Mental Health Center

Community/Rural Health Clinic (or Center)

Crisis Service Provider

Community Service Agency

Hospital (if it includes a distinct behavioral health or detoxification unit)

Inpatient Behavioral Health Facility

Behavioral Health Residential Facility

Residential Treatment Center

Psychiatric Hospital

Substance Use Transitional Center

Unclassified Facility

Integrated Behavioral Health and Medical Facility
# Services

**Partial Care** (supervised day program, therapeutic day program and medical day program)

**Psychosocial Rehabilitation** (living skills training, health promotion and supported employment)

**Psychotropic Medication**

**Psychotropic Medication Adjustment and Monitoring**

## I.

At a minimum every three years, monitor services and service sites that include, but are not limited to, the following:

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>SERVICE SITES</th>
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<tbody>
<tr>
<td>Ancillary</td>
<td>Ambulatory Facilities</td>
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<tr>
<td>Dental</td>
<td>Hospitals</td>
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<tr>
<td>Emergency</td>
<td>Nursing Facilities</td>
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<tr>
<td>Early Periodic Screening, Diagnosis and Treatment (EPSDT)</td>
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<tr>
<td>Family Planning</td>
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<tr>
<td>Obstetric</td>
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<tr>
<td>Pharmacy</td>
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<td>Prevention and Wellness</td>
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<td>Primary Care</td>
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<tr>
<td>Specialty Care</td>
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<tr>
<td>Other (e.g. Durable Medical Equipment (DME)/Medical Supplies, Home Health Services, Therapies, Transportation, etc.)</td>
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</table>
J. At a minimum every three years (unless otherwise noted), monitor services and service sites that include, but are not limited to, the following:

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>SERVICE SITES</th>
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<tbody>
<tr>
<td>Adult Day Health Care*</td>
<td>Ambulatory Facilities</td>
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<tr>
<td>Ancillary</td>
<td>Behavioral Health Facilities</td>
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<tr>
<td>Behavioral Health</td>
<td>Hospice*</td>
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<tr>
<td>Dental</td>
<td>Hospitals</td>
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<tr>
<td>Durable Medical Equipment (DME)/Medical Supplies</td>
<td>Institution for Mental Diseases*</td>
</tr>
<tr>
<td>Emergency</td>
<td>Nursing Facilities*</td>
</tr>
<tr>
<td>Emergency Alert</td>
<td>Residential Treatment Centers*</td>
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<tr>
<td>Early Periodic Screening, Diagnosis and Treatment (EPSDT)</td>
<td>Traumatic Brain Injury Facilities*</td>
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<tr>
<td>Family Planning</td>
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<td>Home Health Services</td>
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<td>Hospice</td>
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<td>Medical/Acute Care</td>
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<td>Obstetric</td>
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<td>Prevention and Wellness</td>
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<tr>
<td>Respiratory Therapy</td>
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<td>Specialty Care</td>
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*These services must be reviewed annually.

K. Annually by December 15th, submit monitoring results to the Division’s Quality Management Unit. A standardized, agreed-upon tool must be used.

General Quality Monitoring of these services includes, but is not limited to, the review and verification of:

1. The written documentation of timeliness
2. The implementation of contingency plans
3. Customer/member satisfaction information
4. The effectiveness of service provision
5. Mandatory documents in the services or service site personnel file:
   a. CPR
   b. First aid
   c. Verification of skills or competencies to provide care

**Implementation of Actions to Improve Care**

A. The AdSS must develop a CAP for taking appropriate actions to improve care if problems are identified. The CAP should address the following:

1. Specified problem(s) requiring the corrective action. Examples include:
   a. Abuse, neglect, and exploitation
   b. Healthcare acquired conditions
   c. Unexpected death
   d. Isolated systemic issues
   e. Trends
   f. Health and safety issues, Immediate Jeopardy and Immediate Care Need situations
   g. Lack of coordination
   h. Inappropriate authorizations for specific ongoing care needs
   i. High profile/media events
2. Person(s) or body (e.g., Board) responsible for making the final determinations regarding quality issues (all determinations regarding quality issues that are referred for peer review will be made only by the Peer Review Committee chaired by the Chief Medical Officer)

Note: See Division Medical Policy 910 for peer review requirements.

3. Type(s) of action(s) to be taken that include, but are not limited to:
   a. Education/training/technical assistance
   b. Follow-up monitoring and evaluation of improvement
   c. Changes in processes, organizational structures, and forms
   d. Informal counseling
   e. Termination of affiliation, suspension or limitation of the provider (if an adverse action is taken with a provider the AdSS must report the adverse action to the Division’s Quality Management Unit within one business day)
   f. Referrals to regulatory agencies

4. Documentation of assessment of the effectiveness of actions taken

5. Method(s) for internal dissemination of findings and resulting CAPs to appropriate staff and/or network providers

6. Method(s) for dissemination of pertinent information to the Division, AHCCCS Administration and/or regulatory boards and agencies (e.g., Arizona Department of Health Services, Arizona Medical Board, Arizona Board of Pharmacy, Arizona State Board of Nursing).

B. The AdSS must maintain documentation confirming implementation of corrective actions.
930 MEMBER RIGHTS AND RESPONSIBILITIES

EFFECTIVE DATE: October 1, 2019

REFERENCES: 9 A.A.C. 34; 42 CFR 438.6, 438.100, 493.3(a)(2); 45 CFR 164, 164.501, 164.524, 164.526; 5 U.S.C. 552(a)

Purpose: To establish guidelines for the Administrative Services Subcontractors (AdSS) to ensure compliance with applicable federal and state laws pertaining to member rights.

Policy: All members have the right to be treated with dignity and respect. The Division of Developmental Disabilities (Division) is committed to protecting the rights of all individuals who are receiving supports and services operated by, supervised by, or financially supported by, the Division. The AdSS must have written policies and procedures that address, at a minimum, the following member rights and how these rights are disseminated to members and providers.

A. Each member has the right to:

1. Be treated with respect and with recognition of the member's dignity and need for privacy.
   a. The right to privacy includes protection of any information that identifies a particular member except when otherwise required or permitted by law.
   b. The AdSS must implement procedures to ensure the confidentiality of health, service and medical records, and of other member information.

2. Not be discriminated against in the delivery of health care services based on race, ethnicity, national origin, religion, gender, age, behavioral health condition (intellectual) or physical disability, sexual preference, genetic information, or source of payment.

3. Have services provided in a culturally competent manner, with consideration for members with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds, and members with visual or auditory limitations. Options include access to a language interpreter, a person proficient in sign language for the hearing impaired, and written materials available in Braille for the blind or in different formats, as appropriate.

4. Have the opportunity to choose a Primary Care Provider (PCP), within the limits of the provider network, and choose other providers, as needed, from among those affiliated with the network. This also includes the right to refuse care from specified providers.

5. Participate in decision-making regarding his/her health care, including:
   a. The right to refuse treatment (42 CFR 438.100), and/or
   b. Have a representative facilitate care or treatment decisions when the member is unable to do so.

6. Be free from any form of restraint or seclusion used as a means of coercion,
7. Be provided with information about formulating Advance Directives (the AdSS must ensure involvement by the member or his/her representative in decisions to withhold resuscitative services, or to forgo or withdraw life-sustaining treatment within the requirements of federal and state law with respect to Advance Directives [42 CFR 438.6]).

8. Complete an Advance Directive. For members in a behavioral health residential setting that have completed an Advance Directive, the document must be kept confidential but readily available (e.g., in a sealed envelope attached to the refrigerator).

9. Receive information, in a language and format that the member understands, about member rights and responsibilities, the amount, duration and scope of all services and benefits, service providers, services included and excluded as a condition of enrollment, and other information including:
   a. Provisions for after hours and emergency health care services. Information provided must notify members that they have the right to access emergency health care services from contracting or non-contracting providers without prior authorization, consistent with the member's determination of the need for such services as a prudent layperson.
   b. Information about available treatment options (including the option of no treatment) or alternative courses of care.
   c. Procedures for obtaining services, including authorization requirements and any special procedures for obtaining mental health and substance use services, or referrals for specialty services not furnished by the member's Primary Care Provider.
   d. Procedures for obtaining services outside the geographic service area of the AdSS.
   e. Provisions for obtaining Division covered services that are not offered or available through the AdSS and notice of the right to obtain family planning services from an appropriate AHCCCS registered provider.
   f. A description of how the organization evaluates new technology for inclusion as a covered benefit.

10. Receive information regarding grievances, appeals, and requests for hearings.

11. Complain about the managed care organization.

12. Have access to review his/her medical records in accordance with applicable federal and state laws.

13. Request and receive annually, at no cost, a copy of his/her medical records as specified in 45 CFR 164.524.
a. The member’s right of access to inspect and obtain a copy of his/her medical records may be denied if the information is:

i. Psychotherapy notes,

ii. Compiled for or in reasonable anticipation of a civil, criminal, or administrative action, or

iii. Protected health information that is subject to the Federal Clinical Laboratory Improvements Amendments of 1988, or exempt pursuant to 42 CFR 493.3(a)(2).

b. An individual may be denied access to read or receive a copy of medical record information without an opportunity for review in accordance with 45 CFR Part 164 if:

i. The information meets the criteria stated in section M above.

ii. The provider is a correctional institution or acting under the direction of a correctional institution as defined in 45 CFR 164.501.

iii. The information is obtained during the course of current research that includes treatment and the member agreed to suspend access to the information during the course of research when consenting to participate in the research.

iv. The information was compiled during a review of quality of care for the purpose of improving the overall provision of care and services.

v. The denial of access meets the requirements of the Privacy Act, 5 USC 552a.

vi. The information was obtained from someone other than a health care provider under the protection of confidentiality, and access would be reasonably likely to reveal the source of the information.

c. Except as provided in Section M above, a member must be informed of the right to seek review if access to inspect or request to obtain a copy of medical record information is denied when:

i. A licensed health care professional has determined the access requested would reasonably be likely to endanger the life or physical safety of the member or another person, or

ii. The protected health information makes reference to another person and access would reasonably be likely to cause substantial harm to the member or another person.

d. The AdSS must respond within 30 days to the member’s request for a copy of the records. The response may be a copy of the records, or if necessary to deny the request, the written denial must include the basis for the denial and written information about how to seek review of the denial in
accordance with 45 CFR Part 164.

14. Amend or correct his/her medical records as specified in 45 CFR 164.526:

a. The AdSS may require the request be made in writing but may not require a specific form be used.

b. If the AdSS agrees to amend information in the member’s medical record, in whole or in part, at a minimum the AdSS must:

   i. Identify the information in the member’s record that is affected and attach or link to the amended information.

   ii. Inform the member, in a timely manner, of the amendment.

   iii. Obtain the member’s agreement to allow the AdSS to notify relevant persons with whom the amendment needs to be shared.

   iv. The AdSS must make reasonable efforts to inform and provide the amendment, within a reasonable time, to:

      a) Persons identified by the member as having received protected health information and who need the amendment, and

      b) Persons, including business associates, that are known to the AdSS as having member information affected by the amendment and who have relied on or may in the future rely on the original information to the detriment of the member.

c. The AdSS may deny the request for amendment or correction if the information:

   i. Would not be available for review (as stated above),

   ii. Was not created by the AdSS or one of its contracted providers, unless the individual provides a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment,

   iii. Is not a part of the member’s medical record, or

   iv. Is already accurate and complete.

d. If the request is denied, in whole or in part, the AdSS must provide the member with a written denial within 60 days that includes:

   i. The basis for the denial;

   ii. The member’s right to submit a written statement disagreeing with the denial, and how to file the statement;
iii. A statement that, if the member does not submit a statement of disagreement, the member may request that the AdSS provide the member’s request for amendment and the denial with any future disclosures of the protected health information that is related to the amendment; and

iv. A description of how the member may seek review of the denial in accordance with 45 CFR 164.

e. The AdSS must ensure that each member is free to exercise his/her rights, and that the exercising of those rights will not adversely affect the treatment of the member by the AdSS or its contracted providers.

f. The Division has adopted the 12 Principles implemented by AHCCCS meant to maintain the integrity of the best practices and approaches to providing behavioral health services for children. AdSS are required to consider and integrate these principles in the provision of behavioral health services for members under the age of 18 years.

g. Each AdSS must have a written policy addressing member responsibilities. Member responsibilities include:

i. Providing, to the extent possible, information needed by professional staff in caring for the member;

ii. Following instructions and guidelines given by those providing health care;

iii. Knowing the name of the assigned Primary Care Provider;

iv. Scheduling appointments during office hours, whenever possible, instead of using urgent care facilities and/or emergency rooms;

v. Arriving for appointments on time;

vi. Notifying the provider in advance when it is not possible to keep an appointment; and

vii. Bringing immunization records to every appointment for children 18 years of age or younger.

h. The AdSS must refer to the Division contract for requirements concerning member handbooks and notification of members regarding their rights and responsibilities. Member rights must be included in the member handbook.

i. The AdSS must refer to 9 A.A.C. 34 and the Division contract for information regarding requirements for the grievance system for members and providers.
940 MEDICAL RECORDS AND COMMUNICATION OF CLINICAL INFORMATION

EFFECTIVE DATE: 10/1/2019
REFERENCES: 42 CFR 431.300 et seq

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

A. The AdSS must have policies and procedures in place for use of electronic medical (care management, physical and behavioral health) records, for use of a health information exchange (including electronic Early and Periodic Screening, Diagnosis and Treatment [EPSDT] tracking forms), and for use of digital (electronic) signatures (when electronic documents are used), that include processes for:

1. Signer authentication
2. Message authentication
3. Affirmative act
4. Efficiency
5. Record review.

B. The AdSS must implement appropriate policies and procedures to ensure that the organization and its providers have information required for:

1. Effective and continuous member care through accurate medical record documentation (including electronic health records) of each member’s health status, changes in health status, health care needs, and health care services provided
2. Quality review
3. Coordination of care
4. An ongoing program to monitor compliance with those policies and procedures.

   If during the quality-of-care review process, or other processes, issues are identified with the quality or content of a provider’s medical record, the AdSS must conduct a focused review and implement corrective actions or other remedies until the provider’s medical records process meets standards specified in Division policy.

C. The AdSS must implement policies and procedures for initial and on-going monitoring of medical records for all contracted primary care physicians (PCPs), Obstetrician/Gynecologists (OB/GYNs), licensed behavioral health professionals, oral health providers, and high-volume specialists (50 or more referrals per contract year by AdSS).

1. The sample of files chosen for medical record review must reflect a
representative Statewide sample.

2. These requirements also apply to professionals employed by, or affiliated with, a contracted provider such as an Accountable Care Organization (ACO). Review of medical records must be conducted every three years.

D. The AdSS must:

1. Conduct medical record reviews, using a standardized tool that has been reviewed by AHCCCS.

2. Conduct medical records reviews at a minimum of every three years.

3. Use a collaborative approach that will result in only one AHCCCS Contractor conducting the “routine” medical record review for each provider.

4. Ensure results of the medical record review will be made available to all Contractors that contract with that provider.

5. Ensure samples are by provider, not by provider group.

6. Use a sample size of 30 records.
   a. If the first eight records reviewed are 100 percent in compliance, the review stops at the eight records.
   b. If deficiencies or variances are found in any of the first eight records reviewed, the full 30 records must be reviewed.

7. Ensure that identified deficiencies are shared with all AHCCCS Contractors contracted with the provider.

E. If the AdSS conducts the medical record review, the AdSS must be responsible for working with the provider on corrective actions. However, other AHCCCS Contractor input into those corrective actions may be necessary and appropriate.

1. If quality-of-care issues are identified during the medical record review process, it is expected that AHCCCS Contractors that contract with that provider be notified promptly of the results in order to conduct an independent on-site provider audit.

2. It is also expected that the AdSS will address noted areas of non-compliance, despite a provider obtaining an overall passing score, to include subsequent follow-up measures taken and/or a corrective action plan required to address the noted deficiency.

F. Each AdSS must implement policies and procedures that address paper and electronic health records, and the methodologies to be used by the organization to:

1. Ensure that contracted providers maintain a legible medical record (including electronic health record/medical record) for each enrolled member who has
been seen for medical or behavioral health appointments or procedures. The medical record must also contain clinical/behavioral health records from other providers who also provide care/services to the enrolled member.

2. Ensure providers, in multi-provider offices, have the treating provider sign his or her treatment notes after each appointment and/or procedure.

3. Ensure the medical record contains documentation of referrals to other providers, coordination of care activities, and transfer of care to behavioral health and other providers.

4. Make certain the medical record is legible, kept up to date, is well organized and comprehensive with sufficient detail to promote effective patient care, quality review, and identifies the treating or consulting provider. A member may have more than one medical record kept by various health care providers that have rendered services to the member. However, the PCP must maintain a comprehensive record that incorporates at least the following components:

   a. Behavioral health information when received from the behavioral health provider about an assigned member even if the provider has not yet seen the assigned member

      In lieu of actually establishing a medical record, such information may be kept in an appropriately labeled file but must be associated with the member’s medical record as soon as one is established.

   b. Member identification information on each page of the medical record (i.e., name or AHCCCS identification number)

   c. Documentation of identifying demographics, including the member’s name, address, telephone number, AHCCCS identification number, gender, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative

   d. Initial history for the member that includes family medical history, social history, and preventive laboratory screenings (the initial history for members under age 21 should also include prenatal care and birth history of the member’s mother while pregnant with the member)

   e. Past medical history, for all members, that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received

   f. Immunization records (required for children; recommended for adult members if available)

   g. Dental history if available, and current dental needs and/or services

   h. Current problem list
i. Current medications

j. Documentation of review of the Controlled Substances Prescription Monitoring Program (CSPMP) database, prior to prescribing a controlled substance or another medication that is known to adversely interact with controlled substances

k. Current and complete EPSDT forms (required for all members age 0 through 20 years)

l. Developmental screening tools for children ages nine, 18 and 24 months

m. Documentation, initialed by the member's provider, to signify review of diagnostic information including:
   i. Laboratory tests and screenings
   ii. Radiology reports
   iii. Physical examination notes
   iv. Other pertinent data

n. Reports from referrals, consultations and specialists

o. Emergency/urgent care reports

p. Hospital discharge summaries

q. Behavioral health referrals and services provided, if applicable, including notification of behavioral health providers, if known, when a member's health status changes or new medications are prescribed

r. Behavioral health history and behavioral health information received from a behavioral health provider who is also treating the member

s. Documentation as to whether or not an adult member has completed advance directives and the location of the document

t. Documentation that the provider responds to behavioral health provider information requests within 10 business days of receiving the request

The response should include:

i. All pertinent information, including, but not limited to, current diagnoses, medications, laboratory results, last provider visit, and recent hospitalizations

ii. The provider's initials signifying review of member behavioral health information received from a behavioral health provider
who is also treating the member.

u. Documentation related to requests for release of information and subsequent releases

v. Documentation that reflects that diagnostic, treatment and disposition information related to a specific member was transmitted to the provider including behavioral health providers, as appropriate to promote continuity of care and quality management of the member’s health care.

5. Ensure that obstetric providers complete a standardized, evidence-based risk assessment tool for obstetric members (i.e. Mutual Insurance Company of Arizona [MICA] obstetric risk assessment tool or American College of Obstetricians and Gynecologists [ACOG] risk assessment tool). Also, ensure that lab screenings for members requiring obstetric care conform to ACOG guidelines.

6. Ensure that PCPs used AHCCCS-approved developmental screening tools.

7. Ensure each organizational provider of services (e.g., hospitals, nursing facilities, rehabilitation clinics, transportation) maintains a record of the services provided to a member that includes:

   a. Physician or provider orders for the service
   b. Applicable diagnostic or evaluation documentation
   c. A plan of treatment
   d. Periodic summary of the member’s progress toward treatment goals
   e. The date and description of service modalities provided
   f. Signature/initials of the provider for each service.

8. Take into consideration professional and community standards and accepted and recognized evidence-based practice guidelines.

9. Ensure the provider has an implemented process to assess and improve the content, legibility, organization, and completeness of member health records when concerns are identified, and

10. Require documentation in the member’s record showing supervision by a licensed professional, who is authorized by the licensing authority to provide the supervision, whenever health care assistants or paraprofessionals provide services.

   a. Medical records may be documented on paper or in an electronic format.
b. If records are documented on paper, they must be written legibly in blue or black ink, signed, and dated for each entry. Electronic format records must also include the name of the provider who made the entry and the date for each entry.

c. If records are physically altered, the person altering the record must identify stricken information as an error, initial, and enter the date on which the change is made; correction fluid or tape is not allowed.

d. If information is kept in an electronic file, the provider must establish a method of indicating the initiator of information and a means to assure that information is not altered inadvertently.

e. If revisions to information are made, a system must be in place to track when, and by whom, they are made. In addition, a backup system including initial and revised information must be maintained.

f. Medical record requirements are applicable to both hard copy and electronic medical records. The AdSS may go on site to review the records electronically or use a secure process to review electronic files received from the provider when concerns are identified.

G. The AdSS must have written policies and procedures addressing appropriate and confidential exchange of member information among providers, including behavioral health providers, and must conduct reviews to verify that:

1. A provider making a referral transmits necessary information to the provider receiving the referral.

2. A provider furnishing a referral service reports appropriate information to the referring provider.

3. Providers request information from other treating providers as necessary to provide appropriate and timely care.

4. Information about services provided to a member by a non-network provider (e.g., emergency services) is transmitted to the member’s Primary Care Provider (PCP).

5. Member records are transferred to the new provider in a timely manner that ensures continuity of care when a member chooses a new PCP.

6. Member information is shared, when a member subsequently enrolls with a new AdSS, in a manner that maintains confidentiality while promoting continuity of care.

7. Member information is shared timely with behavioral health providers for members with ongoing care needs or changes in health status.

8. Information from, or copies of, records may be released only to authorized individuals, and the AdSS must implement a process to ensure that
unauthorized individuals cannot gain access to, or alter, member records.

9. Original and/or copies of medical records must be released only in accordance with Federal or State laws, Division and AHCCCS policy and contracts. AdSS must comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements and 42 CFR 431.300 et seq.

H. The AdSS must participate/cooperate in State of Arizona and Division and AHCCCS activities related to the development and implementation of electronic health records and e-prescribing. Electronic EPSDT tracking forms must include all elements of the EPSDT tracking forms approved by AHCCCS.

I. The AdSS may request approval to discontinue conducting medical record reviews. Prior to receiving approval to discontinue the medical record review process, the AdSS must:

1. Conduct a comprehensive review of its use of the medical record review process and how it is used to document compliance with AHCCCS requirements such as EPSDT, family planning, maternity and behavioral health services.

2. Document what processes will be used, in place of the medical record review process, to ensure compliance with requirements in this policy.

3. Submit the process that the AdSS will use to ensure provider compliance with medical record requirements set forth in this policy to the Division, prior to discontinuing the medical record review process.
950 CREDENTIALING AND REcredentialing PROCESSES

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.A.C. R9-10-112, A.A.C. R9-10-114; 42 CFR 438.68(c)(1)(viii), 42 CFR 438.206 (c)(3), 42 CFR 438.214(b)(1); AHCCCS template, Exhibit 950-1; Section F3, Contractor Chart of Deliverables
DELIVERABLES: Credentialing and Re-credentialing Denials; Credentialing Report

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

This policy covers temporary/provisional credentialing, credentialing, and recredentialing policies for both individual and organizational providers. The credentialing and recredentialing policies must address all providers, including but not limited to acute, primary, behavioral, and substance use disorders [42 CFR 438.214(b)(1)]. The Administrative Services Subcontractors (AdSSs) must process credentialing applications in a timely manner. To assess the timeliness of provisional and initial credentialing the AdSS must follow the guidelines located in the Contract.

The AdSS must submit a Quarterly Credentialing Report, 30 days after the end of the quarter, using the AHCCCS template, Exhibit 950-1.

Credentialing Individual Providers

The AdSS must have a written process and a system in place for credentialing and recredentialing providers included in its contracted provider network. Providers who are not licensed or certified must be included in the credentialing process.

A. Credentialing and recredentialing must be conducted for all providers providing care and services to members eligible for the Division. The AdSS may choose to delegate credentialing to an organizational provider according to requirements outlined in Division Medical Policy Manual, Policy, 910. Credentialing and recredentialing must be completed for at least the following provider types:

1. Physicians (Medical Doctor [MD])
2. Doctor of Osteopathic Medicine [DO]
3. Doctor of Podiatric Medicine (DPM)
4. Nurse practitioners
5. Physician Assistants
6. Certified Nurse Midwives acting as primary care providers, including prenatal care/delivering providers
7. Dentists (Doctor of Dental Surgery [DDS] and Doctor of Medical Dentistry [DMD])
8. Affiliated Practice Dental Hygienists
9. Psychologists
10. Optometrist
11. Certified Registered Nurse Anesthetist
12. Occupational Therapist
13. Speech and Language Pathologist
14. Physical Therapists
15. Independent behavioral health professionals who contract directly with the AdSS and other non-licensed or certified providers that provide behavioral health services including, including:
   a. Licensed Clinical Social Worker (LCSW)
   b. Licensed Professional Counselor (LPC)
   c. Licensed Marriage/Family Therapist (LMFT)
   d. Licensed Independent Substance Abuse Counselor (LISAC)
16. Board Certified Behavioral Analysts (BCBAs)
17. Any non-contracted provider that is rendering services and sees 50 or more members served by the AdSS per contract year
18. Covering or substitute oral health providers that provide care and services to members while providing coverage or acting as a substitute during an absence of the contracted provider.
   Covering or substitute oral health providers must indicate on the claim form that they are the rendering provider of the care of service.

B. The AdSS must ensure:

1. Credentialing and recredentialing processes do not discriminate against a provider who serves high-risk populations or who specializes in the treatment of costly conditions.
2. Compliance with federal requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid or that employ individuals or entities that are excluded from participation.

C. If the AdSS delegates to another entity any of the responsibilities of credentialing/recredentialing that are required by this Policy, it must retain the right to approve, suspend, or terminate any provider selected by that entity and meet the requirements of this Chapter regarding delegation.
D. Written policies must reflect the scope, criteria, timeliness and process for credentialing and recredentialing providers. The policies and procedures must be reviewed and approved by the Contractor’s executive management, and

1. Reflect the direct responsibility of the local Medical Director, or in the absence of the local Medical Director, another local designated physician to:
   a. Act as the Chair of the Credentialing Committee
   b. Implement the decisions made by the Credentialing Committee
   c. Oversee the credentialing process.

2. Indicate the use of participating Arizona Medicaid network providers in making credentialing decisions.

3. Describe the methodology to be used by the AdSS staff and the local AdSS Medical Director to provide documentation that each credentialing or recredentialing file was completed and reviewed, prior to the presentation to the Credentialing Committee for evaluation.

E. The AdSS must maintain an individual electronic or hard copy credentialing/recredentialing file for each credentialed provider. Each file must include all of the following:

   a. The initial credentialing and all subsequent recredentialing applications, including attestation by the applicant of the correctness and completeness of the application as demonstrated by the signature on the application
   b. Information gained through credentialing and recredentialing queries
   c. Utilization data, quality of care concerns, grievances, performance measure rates, value based purchasing results and level of member satisfaction
   d. Any other pertinent information used in determining whether or not the provider met the AdSS’s credentialing and recredentialing standards.

F. Credentialed providers must be entered/loaded into the AdSS’s claims payment system with an effective date of no later than the date the provider was approved by the Credentialing Committee approval.

G. For Locum Tenens, the AdSS must verify the status of the physician with the Arizona Medical Board and national databases.
Initial Credentialing

The AdSS must use the Arizona Health Plan Association’s Credential Verification Organization (CVO) as part of the credentialing process. At a minimum, policies and procedures for the initial credentialing of providers, as required by the Policy must include:

A. Written application to be completed, signed and dated by the provider, that attests to the following elements:
   1. Reasons for any inability to perform the essential functions of the position, with or without accommodation
   2. Lack of present illegal drug use
   3. History of loss of license and/or felony convictions
   4. History of loss or limitation of privileges or disciplinary action
   5. Current malpractice insurance coverage
   6. Attestation by the applicant of the correctness and completeness of the application (a copy of the signed attestation must be included in the provider’s credentialing file)
   7. Minimum five-year work history, or total work history if less than five years.

B. Drug Enforcement Administration (DEA) or Chemical Database Service (CDS) certification, if a prescriber.

C. Verification from primary sources of:
   1. Licensure or certification
   2. Board certification, if applicable, or highest level of credentials attained
   3. For credentialing of Independent Masters Level Behavioral Health Licensed Professionals, including:
      • Licensed Clinical Social Worker (LCSW)
      • Licensed Professional Counselor (LPC)
      • Licensed Marriage and Family Therapist (LMFT)
      • Licensed Independent Substance Abuse Counselor (LISAC).
   Primary source verification of:
   a. Licensure by Arizona Board of Behavioral Health Examiners (AZBBHE)
   b. A review of complaints received and disciplinary status through AZBBHE.
D. For credentialing of Licensed Board Certified Behavioral Health Analysts:

1. Licensure by the Arizona Board of Psychologist Examiners

2. A review of complaints received, board and disciplinary status through the Arizona Board of Psychologist Examiners.

3. Continuing Education requirements

   a. BCBAs credentialed under a 3-Year Cycle: 36 hours every 3 years (3 hours in ethics and professional behavior)

   b. BCBAs credentialed under a 2-Year Cycle: 32 hours every 2 years (4 hours in ethics for all certificates; 3 hours in supervision for supervisors)

4. Continuing Education courses (see table below)

   a. BCBAs providing supervision of individuals pursuing Behavior Analyst Certification Board (BACB) certification or the ongoing practice of Board Certified Assistant Behavior Analysts (BCaBAs) or Registered Behavior Technicians (RBTs) must obtain specific training in order to do so. These individuals must also obtain 3 Continuing Education Units (CEUs) on supervision in every certification cycle.

   b. Acceptable supervision content is behavior-analytic in nature and covers effective supervision as defined in the BACB’s Experience Standards (in particular, the “Nature of Supervision” section) and the BACB Supervisor Training Curriculum Outline.

<table>
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<tr>
<th>TYPE</th>
<th>DESCRIPTION</th>
<th>LIMIT</th>
<th>CEUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>College or university coursework</td>
<td>None – all CE can come from this type</td>
<td>1 hour of instruction = 1 CEU</td>
</tr>
<tr>
<td>2</td>
<td>CE issued by approved continuing education (ACE) providers</td>
<td>None – all CE can come from this type</td>
<td>50 minutes of instruction = 1 CEU</td>
</tr>
<tr>
<td>3</td>
<td>Non-approved events</td>
<td>25% can come from this type*</td>
<td>1 hour = 1 CEU</td>
</tr>
<tr>
<td>4</td>
<td>Instruction of Type 1 or Type 2</td>
<td>50% can come from this type*</td>
<td>1 hour of instruction = 1 CEU</td>
</tr>
<tr>
<td>5</td>
<td>CE issued by the BACB directly</td>
<td>25% can come from this type*</td>
<td>Determined by BACB</td>
</tr>
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</table>
### Quality Management and Performance Improvement Program

#### Chapter 900

##### Credentialing and Recredentialing Processes

<table>
<thead>
<tr>
<th>TYPE</th>
<th>DESCRIPTION</th>
<th>LIMIT</th>
<th>CEUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Take and pass the certification exam again</td>
<td>All CE will be fulfilled by this activity</td>
<td>Passing the exam equals 100% of your required CE, except for supervision</td>
</tr>
<tr>
<td>7</td>
<td>Scholarly Activities</td>
<td>25% can come from this type*</td>
<td>One publication = 8 CEUs One review = 1 CEU</td>
</tr>
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*A maximum of 75% of the total required CE may come from categories 3, 4, 5 and 7. At least 25% must come from Type 1 or Type 2. Passing the examination (Type 6) meets all CE requirements except for supervision.*

#### E. BCBAs providing supervision of individuals pursuing BACB certification or the ongoing practice of BCBAs or RBTs will be required to obtain specific training in order to supervise. These individuals will also be required to obtain three CEUs on supervision in every certification cycle. Acceptable supervision content is behavior-analytic in nature and covers effective supervision as defined in the BACB’s Experience Standards (in particular, the “Nature of Supervision” section) and the BACB Supervisor Training Curriculum Outline.

1. Documentation of graduation from an accredited school and completion of any required internships/residency programs, or other postgraduate training. A print out of license from the applicable Board’s official website denoting that the license is active with no restrictions is acceptable.

2. National Provider Databank (NPDB),

3. Verification of the following:
   a. Minimum five year history of professional liability claims resulting in a judgment or settlement
   b. Disciplinary status with regulatory Board or Agency
   c. Medicare/Medicaid sanctions, and exclusions, and terminations for cause
   d. State sanctions or limitations of licensure
4. Documentation that the following sites have been queried. Any provider that is found to be on any of the lists below may be terminated and the identity of the provider must be disclosed to AHCCCS/Office of the Inspector General (OIG) immediately in accordance with AdSS Operations Manual Policy 103.
   b. The System of Award Management (SAM) www.sam.gov formerly known as the General Services Administration (GSA)

F. Affiliated practice dental hygienists must provide documentation of the affiliation agreement with an AHCCCS registered dentist.

G. Initial site visits for Primary Care Providers (PCP) and Obstetrics/Gynecology (OB/GYN) applicants must include but are not limited to verification of compliance with the following:
   1. Vaccine and drug storage regulations
   2. Emergency and resuscitation equipment policy
   3. Americans with Disabilities Act requirements [42 CFR 438.3(f)(1); 42 CFR 438.100(d)]

H. The AdSS must ensure that network providers have capabilities to ensure physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities [42 CFR 438.206(c)(2)(3)]. AdSS must also ensure that providers deliver services in a culturally competent manner, including to those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. [42 CFR 438.206(c)(2)].

I. The AdSS must conduct timely verification of information, as evidenced by approval (or denial) of a provider within 90 days of a receipt of complete application. The AdSS must send a notification to the provider and load all required information in to AdSS’s system within 30 days of Credentialing Committee approval in order to allow payment to the provider for services. The effective date should be no later than the date of the Credentialing Committee decision or the Contract effective date, whichever is later.

J. The AdSS must have written policies and procedures for notifying practitioners of their right to review information it has obtained to evaluate their credentialing application, attestation or Curriculum Vitae (CV).

K. AdSS providers including licensed or certified behavioral health providers may be subject to an initial site visit as part of the credentialing process.
**Temporary/Provisional Credentialing**

The AdSS must have policies and procedures to address temporary or provisional credentials, when it is in the best interest of members that providers be available to provide care prior to completion of the entire credentialing process.

Temporary, or provisional, credentialing is intended to increase the available network of providers in medically underserved areas, whether rural or urban. Providers working in a Federally Qualified Health Center (FQHC) and FQHC Look-Alike Center, as well as hospital employed physicians (when appropriate), are credentialing using the temporary or provisional credentialing process, even if the provider does not specifically request their application be processed as temporary or provisional.

The AdSS must follow the “Initial Credentialing” guidelines when granting temporary or provisional credentialing to:

- Providers in a Federally Qualified Health Center (FQHC)
- Providers in a FQHC Look-Alike organization
- Hospital employed physicians (when appropriate)
- Providers needed in medically underserved areas
- Providers joining an existing, contracted oral health provider group
- Covering or substitute providers providing services to members during a provider’s absence from the practice.

The AdSS has 14 calendar days from receipt of a completed application, accompanied by the minimum documents specified in the section, in which to render a decision regarding temporary or provisional credentialing. Once provisional/temporary credentialing is approved, provider information must be entered into the AdSS’s information system to allow payment to the provider effective the date the provisional credentialing is approved.

In situations where a covering or substitute provider must be used by a contracted provider and is approved through the temporary/provisional credentialing process, the AdSS must ensure that its system allows payments to the covering/substitute provider effective the date of the notification was received from the provider of the need for a covering or substitute provider. Covering or substitute providers must meet the following requirements:

A. Licensure: Provider and employees rendering services to members must be appropriately licensed in Arizona to render such services as required by state or federal law or regulatory agencies, and such licenses must be maintained in good standing.

B. Restriction of Licensure: Provider must notify the AdSS within two (2) business days of the loss or restriction of his/her DEA permit or license or any other action that limits or restricts the Provider’s ability to practice or provide services.
C. Professional Training: Provider and all employees rendering services to members must possess the education, skills, training, physical and mental health status, and other qualifications necessary to provide quality care and services to members.

D. Professional Standards: Provider and employees rendering services to members must provide care and services which meets or exceeds the standard of care and must comply with all standards of care established by state or federal law.

E. Continuing education: Provider and employees rendering care or services to members must comply with continuing education standards as required by state or federal law or regulatory agencies.

F. Regulatory compliance: Provider must meet the minimum requirements for participating in the Medicaid program as specified by the state.

For consideration of temporary or provisional credentialing, at a minimum, a provider must complete a signed application that includes:

A. Reasons for any inability to perform the essential functions of the position, with or without accommodation

B. Lack of present illegal drug use

C. History of loss of license and/or felony convictions

D. History of loss or limitation of privileges or disciplinary action

E. Current malpractice insurance coverage

F. Attestation by the applicant of the correctness and completeness of the application. A copy of the most current signed attestation will be included in the provider’s credentialing file.

In addition, the applicant must furnish both of the following:

A. Work history for the past five years, or total work history if less than five years

B. Current Drug Enforcement Agency (DEA) or Controlled Drug System (CDS) certificate.

The AdSS must conduct primary verification of the following:

A. Licensure or certification; a printout of license from the applicable board’s official website denoting that the license is active with no restrictions is acceptable.

B. Board certification, if applicable, or the highest level of credential attained, and

C. National Provider Data Bank (NPDB) query, including:

1. Minimum five-year history of professional liability claims resulting in a judgment or settlement
2. Disciplinary status with regulatory board or agency
3. State sanctions or limitations of licenses
4. Medicare/Medicaid sanctions, exclusions, and terminations for cause.

The local AdSS’s Medical Director must review the information obtained and determine whether to grant provisional credentials. Following approval of provisional credentials, the process of verification and Credentialing Committee review, as outlined in this policy, must be completed.

Recredentialing Individual Providers

The AdSS must use the Arizona Health Plan Association’s Credential Verification Organization as part of its credentialing process. At a minimum, the recredentialing policies for physicians and other licensed or certified health care providers must identify procedures that address the recredentialing process and include requirements for:

A. Recredentialing at least every three (3) years
B. An update of information obtained during the initial credentialing process as required in the Initial Credentialing section of this policy
C. Verification of continuing education requirements being met
D. A process for monitoring health care providers specific information, including, but not limited to:
   1. Member concerns, which include grievances (complaints)
   2. Utilization management information (e.g., emergency room utilization, hospital length of stay, disease prevention, pharmacy utilization)
   3. Performance improvement and monitoring (e.g., performance measure rates)
   4. Results of medical record review audits, if applicable
   5. Quality of care issues (including trend data)

     If an adverse action is taken with a provider, including non-renewal of a contract, the AdSS must report the adverse action and include the reason for the adverse action to the Division’s Quality Management Unit within one business day.

   6. Pay for performance and value-driven health care data/outcomes, if applicable
   7. Evidence that the provider’s policies and procedures meet Division requirements
8. Timely approval (or denial) by the AdSS’s Credentialing Committee within three years from the previous credentialing approval date. Primary Source Verification must also be current, within 180 days, for the Committee’s decision.

**Initial Credentialing of Organizational Providers**

A. As a prerequisite to contracting with an organizational provider, the AdSS must ensure the organizational provider has established policies and procedures that meet AHCCCS and Division requirements, including policies and procedures for credentialing and recredentialing if delegated to the organization. The requirements described in this section must be met for all organizational providers in its network, including, but not limited to:

1. Hospitals
2. Home health agencies
3. Nursing facilities
4. Dialysis centers
5. Dental and medical schools
6. Freestanding surgical centers
7. State or local public health clinics
8. Community/Rural Health Clinics (or Centers)
9. Air transportation
10. Non-emergency transportation vendor
11. Laboratories
12. Pharmacies
13. Behavioral health facilities, including but not limited to:
   a. Independent Clinics
   b. FQHCs
   c. Community Mental Health Centers
   d. Level 1 Sub-Acute Facility
   e. Level 1 Sub-Acute Intermediate Care Facility
   f. Level 1 Residential Treatment Center (secure and non-secure)
   g. Community Service Agency
   h. Crisis Services Provider/Agency
   i. Behavioral Health Residential Facility
   j. Behavioral Health Outpatient Clinic
   k. Integrated Clinic
   l. Rural Substance Abuse Transitional Agency
   m. Behavioral Health Therapeutic Home
   n. Respite homes/providers
   o. Specialized Assisted Living Centers
   p. Specialized Assisted Living Homes.

B. Prior to contracting with an organizational provider, the AdSS must:

1. Confirm the provider has met all the state and federal licensing and regulatory requirements (a copy of the license or letter from the regulatory agency will meet this requirement).

2. Confirm the provider is reviewed and approved by an appropriate accrediting body as specified by the Centers for Medicare and Medicaid Services (CMS) (a copy of the accreditation report or letter from the accrediting body will meet this requirement). The AdSS must state in policy which accrediting bodies it accepts that are in compliance with federal requirements.
3. Conduct an onsite quality assessment if the provider is not accredited. The AdSS must develop a process and use assessment criteria, for each type of unaccredited organizational provider with which it contracts; that must include, but is not limited to, confirmation that the organizational provider has:

a. A process for ensuring that the organizational provider credentials its providers for all employed and contracted providers listed in this policy

b. Liability insurance

c. Business license

Centers for Medicare and Medicaid Services (CMS) certification or state licensure review/audit may be substituted for the required site visit if the site visit was within the past three years prior to the credentialing date. In this circumstance, the AdSS must obtain the review/audit documentation from CMS or the state licensing agency and verify that the review/audit was conducted and that the provider meets the AdSS’s standards. A letter from CMS that states the organizational provider was reviewed/audited and passed inspection is sufficient documentation when the AdSS has documented that they have reviewed and approved the CMS criteria and they meet the AdSS’s standards.

d. In addition, Community Service Agencies must also have:

i. A signed relationship agreement with the AdSS whose members they are serving

ii. An approved application with the AdSS

iii. A signed contract with the AdSS-contracted network provider or with contractor directly as applicable.

iv. A description of the services provided that matches the services approved on the Title XIX Certificate

v. Fire inspection reports

vi. Occupancy permits

vii. Tuberculosis testing

viii. CPR certification

ix. First Aid certification

x. Respite providers provide and maintain consistently a signed agreement with an Outpatient Treatment Center.
4. Review and approve the organizational provider through the AdSS’s Credentialing Committee.

5. For transportation vendors, review a maintenance schedule for vehicles used to transport members and the availability of age-appropriate car seats when transporting children.

Reassessment of Organizational Providers

The AdSS must reassess organizational providers at least every three years. The reassessment includes the following information, which must be current:

A. Confirmation the organizational providers remain in good standing with state and federal bodies, and, if applicable, are reviewed and approved by an accrediting body, by validating the organizational provider:
   1. Is licensed to operate in the state, and is in compliance with any other state or federal requirements as applicable
   2. Is reviewed and approved by an appropriate accrediting body.

   If an organizational provider is not accredited or surveyed and licensed by the state, an on-site review is conducted.

B. Review of:
   1. The most current review conducted by the Arizona Department of Health Services (ADHS) and/or summary of findings (date of ADHS review is documented) and, if applicable, review of the online “Hospital Compare” or “Nursing Home Compare”
   2. Record of on-site inspection of non-licensed organizational providers to ensure compliance with service specifications
   3. Supervision of staff and required documentation of direct supervision/clinical oversight as required in A.A.C. R9-10-114. This process must include a review of a valid sample of clinical charts
   4. Most recent audit results of the organizational provider
   5. Confirmation that the service delivery address is verified as correct
   6. Review of staff to verify credentials, and that staff meets the credentialing requirements.

C. Evaluation of organizational provider-specific information such as, but not limited to, the following:
   1. Member concerns which include grievances (complaints)
   2. Utilization management information
3. Performance improvement and monitoring

4. Quality of care issues

5. Onsite assessment.

If an adverse credentialing, recredentialing, or organizational credentialing decision is made, the AdSS must report the adverse action to the Division’s Quality Management Unit within one business day.

D. Review and approval by the AdSS’s Credentialing Committee with formal documentation that includes discussion, review of thresholds, and complaints or grievances.

E. The AdSS must review and monitor other types of organizational providers in accordance with their contract.

**Notification Requirements - Suspensions and Terminations**

A. The AdSS must have procedures for prompt reporting in writing to appropriate authorities including the Division’s Quality Management Unit, the provider’s regulatory board or agency, the Arizona Department of Health Services Licensure Division, and the Office of the Attorney General. The AdSS must report within one business day to the Division’s Quality Management Unit deficiencies that result in a provider’s suspension or termination from the AdSS’s network. If the issue is determined to have criminal implications, including allegations of abuse or neglect, the AdSS must promptly notify a law enforcement agency, and Adult Protective Services or the Department of Child Safety. The AdSS must have an implemented process to report providers to licensing and other regulatory entities all allegations of inappropriate or misuse of prescribing including allegations of adverse outcomes that may have been avoided should the provider have reviewed the CSPMP and coordinated care with other prescribers.

B. The AdSS must report to the Division’s Quality Management Unit all credentialing, provisional credentialing, recredentialing, and organizational credentialing denials that are based on quality-related issues or concerns.

C. The AdSS must indicate in its notification to the Division the reason or cause of the adverse/denial decision and when restrictions are placed on the provider’s contract, such as denials or restrictions that are the result of licensure issues, quality of care concerns, excluded providers, alleged fraud, and waste or abuse. The Division Quality Management Unit will refer cases, as appropriate, to the AHCCCS-OIG. The AHCCCS –OIG will conduct a preliminary investigation to determine if there is sufficient basis to warrant a full investigation. The AdSS must:

1. Maintain documentation of implementation of the procedures

2. Have an appeal process for instances in which the AdSS places restrictions on the provider's contract based on issues of quality of care and/or service
3. Inform the provider of the Quality Management (QM) dispute process through the QM Department

4. Notify the Division’s Quality Management (QM) within one business day for all reported events.

D. Have procedures for reporting to the AHCCCS Clinical Quality Management Unit in writing any final adverse action for any quality-related reason, taken against a health care provider, supplier/vendor, or practitioner. A “final adverse action” does not include an action with respect to a malpractice notice or settlements in which no findings or liability has been made.

E. Submit to the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB):
   1. Within 30 calendar days from the date the final adverse action was taken or the date when the Contractor became aware of the final adverse action, or
   2. By the close of the Contractor’s next monthly reporting cycle, whichever is later.

F. A final adverse action includes:
   1. Civil judgments in federal or state court related to the delivery of a health care item or service
   2. Federal or state criminal convictions related to the delivery of a health care item or service
   3. Actions by federal or state agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including:
      a. Formal or official actions, such as restriction, revocation or suspension of license (and the length of any such suspension), reprimand, censure or probation
      b. Any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise
      c. Any other negative action or finding by such federal or state agency that is publicly available information,
      d. Exclusion from participation in federal or state health care programs as specified in current statute
      e. Any other adjudicated actions or decisions that the Secretary must establish by regulation.
4. Any adverse credentialing, provisional credentialing, recredentialing, or organizational credentialing decision made based on quality-related issues/concerns or any adverse action from a quality or peer review process, that results in denial of a provider to participate in the AdSS network, provider termination, provider suspension or an action that limits or restricts a provider.

G. Notice of an AdSS’s final adverse action should be sent to the Division’s Quality Management Unit within one business day of the notice.

H. The AdSS, its subcontractors and providers are required to immediately notify the AHCCCS Office of Inspector General (AHCCCS-OIG) regarding any allegation of fraud, waste or abuse of the Medicaid Program. Notification to AHCCCS-OIG must be in accordance with AdSS Operations Manual Policy 103 and as specified in Section F3, Contractor Chart of Deliverables. This must include allegations of fraud, waste or abuse that were resolved internally but involved Medicaid funds. The AdSS must also report to the Division, as specified in Section F3, Contractor Chart of Deliverables, any credentialing denials issued by the Credential Verification Organization including, but not limited to those which are the result of licensure issues, quality of care concerns, excluded providers, and which are due to alleged fraud, waste or abuse. In accordance with 42 CFR 455.14, AHCCCS-OIG will then conduct a preliminary investigation to determine if there is sufficient basis to warrant a full investigation.

I. The AdSS must report, within one business day, the following:

1. The name and Tax Identification Number (TIN), as defined in section 7701(A)(41) of the Internal Revenue Code of 1986 (1121)

2. The name (if known) of any health care entity with which the health care provider, supplier, or practitioner is affiliated or associated

3. The nature of the final adverse action and whether such action is on appeal

4. A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information determined by regulation, for appropriate interpretation of information reported under this section

5. The date the final adverse action was taken, its effective date and duration of the action

6. Corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, and

7. Documentation that the following sites have been queried. Any provider that is found to be on any of the lists below may be terminated and the identity of the provider must be disclosed to AHCCCS/OIG immediately in accordance with AdSS Operations Manual, Policy 103:
a. The System of Award Management (SAM)/www.sam.gov, formerly known as the Excluded Parties List System (EPLS)

b. The Social Security Administration’s Death Master File

c. The National Plan and Provider Enumeration System (NPPES)

d. The List of Excluded Individuals (LEIE)

e. Any other databases directed by the Division, AHCCCS or CMS.

Teaching Physicians and Teaching Dentists

AHCCCS permits services to be provided by medical students or medical residents and dental students or dental residents under the direct supervision of a teaching physician or a teaching dentist. In limited circumstances when specific criteria are met, medical residents may provide low-level evaluation and management services to members in designated settings without the presence of the teaching physician.

The teaching physicians and teaching dentists must be an AHCCCS registered provider and must be credentialled by the AdSS in accordance with Division policy as set forth in this policy.

Credentialing Timeliness

The AdSS must process credentialing applications in a timely manner. To assess the timeliness of provisional and initial credentialing, the AdSS must divide the number of complete applications processed (approved/denied) during the time period per category by the number of complete applications that were received during the time period per category. The Division has adopted Exhibit 950-1 in the AHCCCS Medical Policy Manual to be used by the AdSS when submitting the Quarterly Credentialing Report to the Division’s Quality Management Unit through the Division’s Compliance Unit.

The standards for processing, are listed by category below.

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<thead>
<tr>
<th>Type of Credentialing</th>
<th>Timeframe</th>
<th>Completion Requirements</th>
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<tr>
<td>Provisional</td>
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<tr>
<td>Initial</td>
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<td>100%</td>
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<tr>
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<td>100%</td>
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<tr>
<td>Recredentialing</td>
<td>Every Three Years</td>
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<td>Load Times</td>
<td>30 Days</td>
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960 TRACKING AND TRENDING OF MEMBER AND PROVIDER ISSUES

REVISION DATE: October 1, 2019
EFFECTIVE DATE: May 20, 2016
REFERENCES: A.R.S. § 36-517.02, A.A.C. R9-34, R9-21-401 et seq. CFR 431.300 et seq
DELIVERABLES: Advise of Significant Incidents/Accidents; Quality of Care (QOC) Concerns
Opened Report

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The AdSS must develop and implement policies and procedures to review, evaluate, and resolve quality of care and service issues raised by members, contracted providers, and stakeholders. The issues may be received from anywhere within the organization or externally from anywhere in the community. All issues must be addressed regardless of source (external or internal).

Documentation Related to Quality of Care Concerns

As a part of the AdSS’s process for reviewing and evaluating member and provider issues, there are written procedures regarding the receipt, initial and ongoing processing of these matters that include requirements that the AdSS perform the following:

A. Document each issue raised, when it was raised, from whom it was received, and the projected time frame for resolution.

B. Determine promptly whether one of the following processes will be used to resolve the issue:
   1. Quality management process
   2. Grievance and appeals process
   3. Process for making initial determinations on coverage and payment issues
   4. Process for resolving disputed initial determinations.

C. Acknowledge receipt of the issue and explain to the member/responsible person or provider the process that will be followed to resolve their issue through written correspondence.

D. For issues that are submitted to the Quality Management (QM) Unit but are determined to not be a Quality of Care (QOC) concern, inform the submitter of the process to be used to resolve the issue. QOC-related concerns must be addressed in the QM Unit.

E. Assist the member or provider as needed to complete forms or take other necessary actions to obtain resolution of the issue.

F. Ensure confidentiality of all member information.

G. Inform the member or provider of all applicable mechanisms for resolving the issue that are external to the AdSS processes.
H. Document all processes (including detailed steps used during the investigation and resolution stages) implemented to ensure complete resolution of each complaint, grievance or appeal, including but not limited to:

1. Corrective action plan(s) or action(s) taken to resolve the concern
2. Documentation that education/training was completed. This may include, but is not limited to, in-service attendance sheets and training objectives.
3. New policies and/or procedures
4. Follow-up with the member that includes, but is not limited to:
   a. Assistance as needed to ensure that the immediate health care needs are met
   b. Closure/resolution letter that provides sufficient detail to ensure all covered, medically necessary care needs are met, and a contact name/telephone number to call for assistance or to express any unresolved concerns.
5. Referral to the AdSS’s Corporate Compliance Units and/or AHCCCS Office of the Inspector General.

I. Refer to A.A.C. R9-34 and the Division Contract for information regarding requirements for the grievance and appeal system for members and providers.

Process of Evaluation and Resolution of Quality of Care and Service Concerns

The quality of care concerns process must include documentation of identification, research, evaluation, intervention, resolution, and trending of member and provider issues. Resolution include both member and system interventions when appropriate.

The quality of care/service concerns process must be a stand-alone process completed through the Quality Management Unit. The process must not be combined with other agency meetings or processes. Work units outside of the QM Unit will not have the authority to conduct quality of care investigations but may provide subject matter expertise throughout the investigative process.

A. The AdSS must develop and implement policies and procedures that address analysis of quality of care issues through:

1. Identification of the quality of care issues
2. Initial assessment of the severity of the quality of care issue
3. Prioritization of action(s) needed to resolve immediate care needs when appropriate
4. Review of trend reports obtained from the AdSS’s quality of care data system to determine possible trends related to the provider(s), including
organizational providers, involved in the allegation(s) including but not limited to types of allegation(s), severity, and substantiation

5. Research, including, but not limited to:
   a. A review of the log of the events
   b. Documentation of conversations
   c. Medical records review
   d. Mortality review

6. Quantitative and qualitative analysis of the research, which may include root cause analysis

7. Direct interviews of members, staff, and witnesses to a reportable event; when applicable and appropriate.

B. The AdSS’s Quality Management staff must conduct onsite visits in response to identified health and safety concerns, immediate jeopardy, serious incident situations, a request of the Division or AHCCCS.

Subject matter experts outside the QM Unit may participate in the onsite visit but may not take the place of Quality Management staff during reviews. SMEs may arrive on site first if they are closer to the site, however, a clinical QM staff member must be the lead for the review/investigation and participate in the onsite visits.

The AdSS may not delegate quality of care investigation processes or onsite quality of care visits. Quality investigations may not be delegated or performed by the staff of the provider agency/facility where the identified health and safety concerns, Immediate Jeopardy, or AHCCCS-requested reviews have occurred. Contractors must complete and submit to AHCCCS Attachment 960-C for each onsite review.

Based on findings, the AdSS must:

1. Actively participate in meetings focused on ensuring health and safety of members.

2. Actively participate in meetings scheduled to develop work plans and corrective action plans to ensure placement setting or service sites compliance with ADHS Licensure and/or AHCCCS requirements.

3. Participate in scheduled and unscheduled monitoring of placement setting or service sites that are in an Immediate Jeopardy status, have serious identified deficiencies that may affect health and safety of members or as directed by AHCCCS.

4. Assist in the identification of technical assistance resources focused on achieving and sustaining regulatory compliance.
5. Monitor placement setting or service sites upon completion of the activities and interventions to ensure that compliance is sustained.

C. The AdSS must develop a process to assure that action is taken when needed by:

1. Developing an action plan to reduce/eliminate the likelihood of the issue reoccurring
2. Determining, implementing, and documenting appropriate interventions
3. Monitoring and documenting the success of the interventions
4. Incorporating interventions into the organization's QM program if successful
5. Implementing new interventions/approaches when necessary.

D. The AdSS must develop a process to ensure resolution of the issue. Member and system resolutions may occur independently from one another.

E. The AdSS must develop a process to determine the level of severity of the QOC issue.

F. The AdSS must develop a process to refer and/or report the issues to the appropriate regulatory agency(ies) identified below:

1. The Department of Child Safety
2. Adult Protective Services
3. Arizona Department of Health Services (AZDHS)
4. The Attorney General’s Office
5. Law enforcement
6. The Division or AHCCCS
7. Other entities as necessary.

Initial reporting may be made verbally, but a verbal report must be followed by a written report within one business day.

G. The AdSS must have a process to refer the issue to the AdSS’s Peer Review Committee when appropriate. Referral to the Peer Review Committee is not a substitute for implementing interventions aimed at individual and systemic quality improvement.

H. If an adverse action is taken with a provider for any reason including those related to quality of care concern, the AdSS must report the adverse action to the Division’s QM Unit within 24 hours of the determination to take an adverse action and to the National Practitioner Data Bank when needed.
I. The AdSS must ensure a thoughtful process around member impact and care transition when acting on adverse actions. This is particularly important if a provider is being suspended or terminated. The Contractor must allow adequate time for identification of new providers, transition of members to those providers, impact to members (such as service plans, medications, etc.), and timely communication to members to prepare for the transition. While there may be instances where a move or transition must occur quickly, the MCO should work with AHCCCS to ensure member needs are met without potential gaps in care/services and or treatment disruption.

J. The AdSS must have a process to document the criteria and process for closure of the review or investigation. Required documentation includes, but is not limited to, the following:

1. A description of the problems, including new allegations identified during the investigation/review process, and the substantiation and severity level for each allegation and the case overall.

2. Written response from, or summary of, the documents received from referrals made to outside agencies such as accrediting bodies, or Medical Examiner.

3. Interventions imposed as part of the investigation (such as education, root/cause analysis, and ongoing monitoring).

K. The AdSS must document, in the QOC file, investigations that warrant ongoing monitoring or follow-up with the provider. All follow-up actions or monitoring activities as well as related observations or findings must be documented in the QOC file.

L. The AdSS must notify the Division’s QM Unit and take appropriate action with the provider, including suspension or corrective action plans and referrals to appropriate regulatory Boards including the Pharmacy Board, when an investigation identifies an adverse outcome, including mortalities, due to prescribing issues or failure of the provider to:

1. Check the CSPMP

2. Coordinate care with other prescribers

3. Refer for substance use treatment or pain management.

The case finding must be presented to the AdSS’s Peer Review Committee for discussion and review.
Requests for Copies of Death Certificates

As part of the quality of care investigative process, the AdSS will request copies of member death certificates from the ADHS Bureau of Vital Records.

A. Authorization of Requestors

The AdSS must:

1. Create a letter, on AdSS letterhead, providing one or two names of employees who are authorized to make a request for a copy of the death certificate. The requestor should be someone at a manager of supervisory level position with the AdSS.

   Only those individual(s) listed on the letter are eligible to apply/request a copy of the death certificate.

2. Ensure the letter includes original ink signatures and is mailed to:

   Arizona Department of Health Records
   Bureau of Vital Records
   Office Chief
   P.O Box 3887
   Phoenix, Arizona 85030

3. Notify the AZDHS Office of Vital Statistics in writing of any termination of employment of those listed on the original letter. Include in the notification the name of the replacement managerial or supervisory staff person. Mail these changes to:

   Operations Section Manager
   Arizona Department of Health Services
   Bureau of Vital Records
   P.O Box 3887
   Phoenix, Arizona 85030

B. Requesting Copies of Death Certificates

When requesting a death certificate, the AdSS authorized requestor must:

1. Include the following in the request:
   
a. The decedent’s (member’s) name

   b. Date of death

   c. Purpose of request (i.e. quality of care investigation process)

   d. Signature of the authorized employee (requests must be mailed with original ink signatures)
e. Documentation showing that the decedent was a member of the Division (copy of an eligibility screen with the Division’s name, members name and date of eligibility is acceptable)

f. A payment of $5.00 for each copy requested, in the form of a business check, money order, or credit card.

2. Send the request for a death certificate to:

   Arizona Department of Health Records
   Bureau of Vital Records
   Office Chief
   P.O Box 3887
   Phoenix, Arizona 85030

**Reporting to Independent Oversight Committee**

The AdSS must provide Incident, Accident and Death Reports concerning issues including, but not limited to, reports of possible abuse, neglect or denial of rights to the Division’s Independent Oversight Committee (IOC) as outlined in this policy. All incident, accident and death reports must have all personally identifiable information redacted in accordance with federal and state confidentiality laws.

A. When the Division or a IOC requests information regarding the outcome of a report of possible abuse, neglect or violation of rights, the AdSS must do one of the following:

1. Conduct an investigation of the incident if it has not already been conducted:

   a. For incidents in which a person currently or previously enrolled as seriously mentally ill is the possible victim, the investigation shall follow the requirements in A.A.C. R9-21-401 et seq.

   b. For incidents in which a currently or previously enrolled child or non-seriously mentally ill adult is the possible victim, the investigation shall be completed within 35 days of the request and shall determine: all information surrounding the incident, whether the incident constitutes abuse, neglect, or a violation of rights, and any corrective action needed as a result of the incident.

2. If an investigation has already been conducted by the AdSS and can be disclosed without violating any confidentiality provisions, the AdSS must provide the final investigation decision to the Division and the IOC. The final investigation decision shall consist of, at a minimum, the following information:

   a. The accepted portion of the investigation report with respect to the facts found,

   b. A summary of the investigation findings, and
c. Conclusions and corrective action taken.

Personally identifiable information regarding any currently or previously enrolled person shall not be included in the final investigation decision provided to the IOC, unless otherwise allowed by law.

B. General Requirements

1. The AdSS must provide to IOC’s member information and records in accordance with A.R.S. §41-3804. The following items must be routinely provided to the IOC in redacted format:
   a. Seclusion and Restraint reports
   b. Incident/Accident/Death (IAD) reports, and/or
   c. Quality of Care (QOC) investigations as applicable.

Upon review of supplied information, the IOC may request documentation, supplemental information, or an investigation regarding alleged violation of rights.

2. The AdSS must provide Seclusion and Restraint Reports, and IAD Reports concerning issues including, but not limited to, reports of possible abuse, neglect or denial of rights to IOC’s as specified in Section F3, Contractor Chart of Deliverables. All Seclusion and Restraint Reports and IAD reports must have all information removed that personally identifies members, in accordance with federal and state confidentiality laws, and

3. If a QOC investigation has already been conducted by the AdSS and can be disclosed without violating any confidentiality provisions, the AdSS must provide the requested documentation to the IOC via the Secured Quality Management System Portal.

Requests for Protected Health Information (PHI) of a Currently Enrolled Member

A. When an IOC requests PHI concerning a currently or previously enrolled member, the IOC must first demonstrate that the information is necessary to perform a function that is related to the oversight of the behavioral health system or the IOC must have written authorization from the member to review PHI.

B. If it is determined that the IOC needs PHI and has obtained the member’s or representative’s written authorization, the AdSS must first review the requested information and determine if any of the following types of information are present: Communicable disease related information, including confidential HIV information, and/or information concerning diagnosis, treatment or referral from an alcohol or drug use program. If no such information is present, the AdSS must provide the information adhering to the requirements of this policy.

1. If communicable disease related information, including confidential HIV information, and/or information concerning diagnosis, treatment or referral from an alcohol or drug use program is found, the AdSS must:
a. Contact the member or representative if an adult, or the custodial parent or legal guardian if the member is a child, and ask if the member is willing to sign an authorization for the release of communicable disease related information, including confidential HIV information, and/or information concerning diagnosis, treatment or referral from an alcohol or drug use program. The AdSS must provide the name and telephone number of a contact person with the IOC who can explain the Committee’s purpose for requesting the protected information. If the member agrees to give authorization, the AdSS must obtain written authorization as required below and provide the requested information to the IOC.

b. Authorization for the disclosure of records of deceased members may be made by the executor, administrator, or other personal representative appointed by will or by a court to manage the deceased member’s estate. If no personal representative has been appointed, PHI may be disclosed to a family member, other relative, or a close personal friend of the deceased member, or any other person identified by the deceased, only to the extent that the PHI is directly relevant to such person’s involvement with the deceased member’s health care or payment related to the individual’s health care.

c. If the member does not authorize the release of the communicable disease-related information, including confidential HIV information and/or information concerning diagnosis, treatment or referral from an alcohol or drug use program, this information must not be included or must be redacted from any PHI that is authorized to be disclosed, and

d. Requested information that does not require the member or representative’s authorization must be provided within 15 working days of the request. If the authorization is required, requested information must be provided within five working days of receipt of the written authorization.

C. When PHI is sent, the AdSS must include a cover letter addressed to the IOC that states that the information is confidential, is for the official purposes of the Committee, and is not to be re-released under any circumstances.

D. If the Division denies the IOC’s request for PHI:

1. The Division notifies the IOC within five working days that the request is denied, the specific reason for the denial, and that the Committee may request, in writing, that the Division Director, or designee, review this decision. The Committee’s request to review the denial must be received by the Division Director, or designee, within 60 days of the first scheduled committee meeting after the denial decision is issued,

2. The Division Director, or designee, conducts the review within five business days after receiving the request for review,
3. The Division Director’s or designee’s decision is the final agency decision and is subject to judicial review pursuant to A.R.S. Title 12, Chapter 7, Article 6, and

4. No information or records can be released during the timeframe for filing a request for judicial review or when judicial review is pending.

**Authorization Requirements**

A written authorization for disclosure of information concerning diagnosis, treatment or referral from an alcohol or substance use program and/or communicable disease related information, including confidential HIV information, must include all of the following:

A. The specific name or general designation of the program or person permitted to make the disclosure

B. The name or title of the individual or the name of the organization to which the disclosure is to be made

C. The name of the currently or previously enrolled member

D. The purpose of the disclosure

E. How much and what kind of information is to be disclosed

F. The signature of the currently or previously enrolled member/legal guardian and, if the currently or previously enrolled member is a minor, the signature of a person authorized to give consent

G. The date on which the authorization is signed

H. A statement that the authorization is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it

I. The date, event, or condition upon which the authorization will expire if not revoked before. This date, event, or condition must ensure that the authorization will last no longer than reasonably necessary to serve the purpose for which it is given

J. A statement that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2) and state statute on confidentiality of HIV/AIDS and other communicable disease information (A.R.S. §36-664(H)) which prohibit further disclosure of this information unless further disclosure is expressly permitted by the written consent of the member to whom it pertains, or as otherwise permitted by 42 CFR Part 2 and A.R.S §36-664(H). A general authorization for the release of medical or other information is NOT sufficient for this purpose.

The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
**Problem Resolution**

If any problems with receipt of requested information as provided in this policy arise, the AdSS must notify the Division and the IOC in writing within the first 30 days. If the problem is not resolved, the IOC may then address the problem to the Division Director or designee.

**Duties and Liabilities of Behavioral Health Providers in Proving Behavioral Health Services**

A. The AdSS must develop and make available written policies and procedures that provide guidance regarding the provider’s duty to warn under A.R.S. § 36-517.02. This statute supplements other immunities of behavioral health providers or mental health treatment agencies that are specified in law.

With respect to the legal liability of a behavioral health provider, A.R.S. § 36-517.02 provides that no cause of action or legal liability may be imposed against a behavioral health provider for breaching a duty to prevent harm to a person caused by a patient unless both of the following occur:

1. The patient has communicated to the mental health provider an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the patient has the apparent intent and ability to carry out such threat.

2. The mental health provider fails to take reasonable precautions.

B. A.R.S. § 36-517.02 provides that any duty of a behavioral health provider to take reasonable precautions to prevent harm threatened by a patient is discharged when the behavioral health provider:

1. Communicates when possible the threat to all identifiable victims,

2. Notifies a law enforcement agency in the vicinity where the patient or any potential victim resides,

3. Takes reasonable steps to initiate voluntary or involuntary hospitalization, if appropriate, or

4. Takes other precautions that a reasonable, prudent behavioral health provider would take under the circumstances.

C. This statute also provides immunity from liability when the behavioral health provider discloses confidential communications by or relating to a patient under certain circumstances: The behavioral health provider has no liability resulting from disclosing a confidential communication made by or relating to a patient when a patient has explicitly threatened to cause serious harm to a person or when the behavioral health provider reasonably concludes that a patient is likely to cause harm, and the behavioral health provider discloses a confidential communication made by or relating to the patient to reduce the risk of harm.
All providers, regardless of their specialty or area of practice, have a duty to protect others against a member’s potential danger to self and/or danger to others. When a provider determines, or under applicable professional standards, reasonably should have determined, that a patient poses a serious danger to self or others, the provider must exercise care to protect others against imminent danger of a patient harming him/herself or others. The foreseeable victim need not be specifically identified by the member, but he/she may be someone who would be the most likely victim of the member’s dangerous conduct.

The responsibility of behavioral health provider to take reasonable precautions to prevent harm threatened by a member may include any of the following:

1. Communicating, when possible, the threat to all identifiable victims,
2. Notifying a law enforcement agency in the vicinity where the member or any potential victim resides,
3. Taking reasonable steps to initiate proceedings for voluntary or involuntary hospitalization, if appropriate, and in accordance with AMPM Policy 320-U, or
4. Taking any other precautions that a reasonable and prudent provider would take under the circumstances.

**Tracking and Trending of Quality of Care Issues**

A. The AdSS must develop and implement a system to document, track, trend, and evaluate complaints and allegations received from members and providers or as requested by AHCCCS, inclusive of quality care, quality of service and immediate care need issues.

B. The data from the quality of care data system must be analyzed and evaluated to determine any trends related to the quality of care or service in the AdSS’s service delivery system or provider network. The AdSS must incorporate trending of quality of care issues in determining systemic interventions for quality improvement.

C. The Division documents quality tracking and trending information and documentation that the information was submitted, reviewed, and considered for action by the Division’s Quality Committee and Chief Medical Officer, as Chairman of the QM Committee.

D. The AdSS submits quality tracking and trending information from all closed quality of care issues within the reporting quarter to the Division’s QM Unit, utilizing the Quarterly Quality Management Report template provided by AHCCCS. The report is due 30 days after the end of each quarter, the Division line(s) of business must be reported separately and must include the following reporting elements:

1. Types and number/percentages of substantiated quality of care issues
2. Intervention implemented to resolve and prevent similar incidents
3. Resolution status of “substantiated,” “unsubstantiated,” and “unable to
substantiate” quality of care issues.

If significant negative trends are noted, the AdSS may consider developing performance improvement activities focused on the topic area to improve the issue resolution process itself, and to make improvements that address other system issues raised during the resolution process.

E. The AdSS submits to the Division all pertinent information regarding an incident of abuse, neglect exploitation, unexpected death (including all unexpected transplant deaths), and other serious incidents as determined by the Division or AHCCCS, via a written Incident Report to the Division no later than 24 hours after becoming aware of the incident. For more information regarding Incident Reporting see Section 6002 in the Division’s Operations Policy Manual. Pertinent information must not be limited to autopsy results and must include a broad review of all issues and possible areas of concern. Delays in receipt of autopsy results must not result in delays of the AdSS’s investigation of a quality of care concern. Delayed autopsy results must be used by the AdSS to confirm the resolution of the quality of care concern.

F. The AdSS must ensure member health records are available and accessible to authorized staff of its organization and to appropriate state and federal authorities, or their delegates, involved in accessing quality of care/service or investigating member or provider quality of care concerns, complaints, allegation of abuse, neglect exploitation, serious incidents, grievances, Provider Preventable Conditions and Healthcare Acquired Conditions (HCAC). Member record availability and accessibility must be in compliance with federal and state confidentiality laws, including, but not limited to, Health Insurance Portability and Accountability Act (HIPAA) and CFR 431.300 et seq.

G. The AdSS must maintain information related to coverage and payment issues for at least five years following final resolution of the issue and must be made available to the member, provider, and/or Division or AHCCCS authorized staff upon request.

H. The AdSS must proactively provide care coordination for members who have multiple complaints regarding services.

**Provider-Preventable Conditions**

A. Payments are prohibited for services related to Provider-Preventable Conditions. Provider-Preventable Condition means a condition that meets the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC).

If an HCAC or OPPC is identified, the AdSS must:

1. Conduct a quality of care investigation, and maintain case files containing findings.

2. Report the occurrence and results of the investigation to the Division’s QM Unit quarterly, as specified in the Contract.
B. The terms HCAC and OPPC are defined as follows:

1. Health Care Acquired Condition (HCAC) – means a Hospital Acquired Condition (HAC) under the Medicare program that occurs in any inpatient hospital setting and is not present on admission. (Refer to the current CMS list of Hospital-Acquired Conditions, located at www.cms.gov.)

2. Other Provider Preventable Conditions (OPPC) – means a condition occurring in the inpatient and outpatient health care setting which is limited to the following:
   a. Surgery on the wrong member
   b. Wrong surgery on a member
   c. Wrong site surgery.
970 PERFORMANCE MEASURES

EFFECTIVE DATE: October 1, 2019
REFERENCE: 42 CFR 438.330, 42 CFR 438.334(a) (1) and (2) and (3); AHCCCS Medical Policy Manual, Appendix A, EPSDT and Adult Quarterly Monitoring Report Instructions and Templates; Section F3, Contractor Chart of Deliverables

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

The Division of Development Disabilities (Division) uses AHCCCS’s performance metrics and measures, when monitoring the Administrative Services Subcontractors (AdSS) ability to meet contractual requirements related to the delivery of care and services to members.

Triple Aim

In the metric performance measure set, attention was paid to the goals coined by the Institute for Health Improvement (IHI) and adopted by the Centers for Medicare and Medicaid Services, which is called the “Triple Aim.” IHI defines the Triple Aim as a “framework for optimizing health system performance.” There are three components to the Triple Aim:

A. Improve the experience and outcomes of care.
B. Improve the health of populations.
C. Reduce the per capita costs of healthcare.

The components of the Triple Aim must be balanced in order to reach the overarching goal of optimizing the healthcare system. In order to achieve the Triple Aim, an accurate, reliable and valid health information system is necessary and required. The health information analytics system must be able to aggregate and analyze clinical, service, financial, and patient experience of care data in order to standardize best practices, implement targeted interventions and track improvement over time.

Examples of how the three components of the Triple Aim may be implemented include:

A. Improve the experience of care.
   Offer incentives and penalties to improve the experience of care, such as:
   1. Meeting the Value-Based Payment (VBP) patient satisfaction goals
   2. The Consumer Assessment of Healthcare Providers and Services (CAHPS)
B. Improve the health of populations.

1. Provide payment based on quality, such as:
   a. Achieving quality metrics
   b. Meeting pay-for-performance/quality or value based purchasing metrics.

2. Establish opportunities for clinically integrated care via:
   a. Implementation/use of the Health Information Exchange
   b. Increased use of electronic health records
   c. Creating disease registries
   d. Providing clinician and member portals
   e. Offering Patient Centered Medical Homes
   f. Using Accountable Care Organizations
   g. Providing population health initiatives that:
      i. Support and encourage patient engagement.
      ii. Incorporate mobile applications for patients achieving health goals.

C. Reduce the cost of health care reform delivery and payment systems to provide better care in a cost-efficient manner by:

1. Structuring payment based on quality
2. Rewarding increased access to care
3. Developing methods to use electronic health records for care coordination and quality improvement.

Core/Measure Sets Healthcare Effectiveness Data and Information Set

The Division uses delegated AHCCCS’s Performance Measures based on the Centers for Medicare and Medicaid Services (CMS) Core/Measure Sets Healthcare Effectiveness Data and Information Set (HEDIS-like) developed by the National Committee for Quality Assurance (NCQA), or other methodologies, as an integral component of its Quality Management/Performance Improvement (QM/PI) program. Each AdSS is expected to use the same performance measures.
The Division may also add additional performance measures. Examples of areas that may be measured include maternal and child health services, wellness and screening services, disease management processes, readmissions, emergency department, use of services, and non-clinical areas such as access to care, placement at appropriate level of care, supervision of providers, provider turnover, interpreter services, and cultural competency.

The measures will consider underlying performance, performance gaps, reliability and validity, feasibility, and alignment. The measures will support and align with an AdSS’s quality assessment and performance improvement program (42 CFR 438.330).

The performance measures are used to evaluate whether the AdSS is fulfilling key contractual obligations. Such performance measures established or adopted by AHCCCS are also an important element of the approach to transparency in health services and value-based purchasing. Performance is publicly reported on the AHCCCS website such as in its report cards and rating systems, and through other means, such as sharing of data with state agencies and other community organizations and stakeholders. The performance of the Division’s ADSS is compared to AHCCCS requirements and to national Medicaid and commercial health plan means as well as goal established by the Centers for Medicare and Medicaid Services.

CMS may, in consultation with states and other stakeholders, specify standardized performance measures and topics for performance improvement projects (PIPs) for inclusion alongside state-specified measures and topics in state contracts (42 CFR 438.330[a][2]). The AdSS is required to participate in performance measures and performance improvement projects that are mandated by CMS.

Performance Measures must be reported to the Division’s Quality Management Unit as specified in Section F3, Contractor Chart of Deliverables. Performance measures must be analyzed and reported separately, by line of business. In addition, the AdSS should evaluate performance based on sub-categories of populations when reasonable to do such.

**QUALITY RATING SYSTEM**

The Division has adopted AHCCCS’ quality rating system to provide additional oversight and guidance to AdSS. The quality rating system will measure and report on performance data collected from each contractor on a standardized set of measures that will be determined by CMS as well as state identified measures. The components of the rating system will be based on three summary indicators: (1) Clinical quality management, (2) Member experience, and (3) Plan efficiency, affordability, and management (42 CFR 438.334[a] [1] and [2] and [3]).
Quality Management Performance Measure Requirements

The AdSS must comply with Division and AHCCCS quality management requirements to improve performance in all Division and AHCCCS established performance measures. Descriptions of the AHCCCS Clinical Quality Performance Measures can be found in the most recently published reports of Acute Care Performance Measures located on the AHCCCS website. All performance measure descriptions, forms, and methodologies for specific measures, can also be found on the AHCCCS Performance Measures website. The AdSS is responsible for applying the correct performance measure methodologies including the CMS-416 methodology for its internal monitoring of performance measure results.

The AdSS must:

A. Achieve at least the Minimum Performance Standards (MPS) established by the Division or AHCCCS for each measure, based on the rate calculated by AHCCCS or,

B. Develop an evidence-based Corrective Action Plan (CAP) for each measure not meeting the MPS to bring performance up to at least the minimum level established by the Division or AHCCCS.

Plan Do Study Act and Repeat Cycle

1. **Plan:** Plan the change(s) or intervention(s), including a plan for collecting data. State the objective(s) of the intervention(s).

2. **Do:** Try out the intervention(s) and document any problems or unexpected results.

3. **Study:** Analyze the data and study the results. Compare the data to predictions and summarize what was learned.

4. **Act:** Refine the change(s)/intervention(s), based on what was learned, and prepare a plan for retesting the intervention(s).

5. **Repeat:** Continue the cycle as new data becomes available until improvement is achieved.

C. Receive Division approval prior to implementation. Each CAP must minimally require the actions described below.

1. Document the results of an evaluation of existing interventions to achieve Division and AHCCCS performance standards, including barriers to use of services and/or reasons why the interventions have not achieved the desired effect (Plan).

2. Identify new or enhanced interventions that will be implemented in order to bring performance up to at least the minimum level established by the Division and AHCCCS, including evidence-based practices that have been shown to be effective in the same/similar populations (Plan).
3. Demonstrate that the AdSS is allocating increased administrative resources to improving rates for a particular measure or service area \((Do)\).

4. Identify staff positions responsible for implementing/overseeing interventions with specific timeframes for implementation \((Do)\).

5. Provide a means for measuring the results of new/enhanced interventions on a frequent basis \((Study)\).

6. Provide a means for refining interventions based on what is learned from testing different approached or activities \((Act)\).

7. Describe a process for repeating the cycle until the desired effect – a rate that meets or exceeds the minimum level established by the Division and AHCCCS is achieved.

D. Monitor and report to the Division the status of and any discrepancies identified in encounters submitted to and received by the Division including paid, denied, and pended encounters for purposes of Performance Measure monitoring. The AdSS is responsible for monitoring encounter submissions by its subcontractors.

E. Shows demonstrable improvement from year to year, which is sustained over time, in order to meet goals for performance established by the Division and AHCCCS.

F. Comply with national performance measures and levels that may be identified and developed by the CMS in consultation with AHCCCS or relevant stakeholders.

1. The AdSS’s QM/PI Program must internally measure and report to the Division its performance for contractually mandated performance measures, using standardized methodology established or adopted by the Division or AHCCCS. These results should be reported to AHCCCS and the Division’s Compliance Unit using the Early Periodic Screening, Diagnosis and Treatment (EPSDT) and adult quarterly monitoring report as adopted by the Division. Refer to AHCCCS Medical Policy Manual Appendix A (EPSDT and Adult Quarterly Monitoring Report Instructions and Templates) for more details. The AdSS calculated and/or reported rates will be used strictly for monitoring the effectiveness of the AdSS actions/interventions and will not be used by the Division or AHCCCS for official reporting or for corrective action purposes.

2. The AdSS must use the results of the Division and AHCCCS performance measure in evaluating its quality assessment and performance improvement program.

3. The AdSS must shows demonstrable and sustained improvement toward meeting Division and AHCCCS Performance Standards. The Division may impose sanctions on an AdSS that does not show statistically significant improvement in a measure rate as calculated by the Division or AHCCCS. Sanctions may also be imposed for statistically significant declines of rates, even if they meet or exceed the MPS, for any rate that does not meet the Division or AHCCCS MPS, or at a rate, that has significant impact to the
aggregate rate for the State. The Division may require the AdSS to demonstrate that it is allocating increased administrative resources to improving rates for particular measure or service area. The Division may also requires a CAP for measures that are below the MPS or that show a statistically significant decrease in its rate, even if it meets or exceeds the MPS.

G. The AdSS may be directed to collect all or some data used to measure performance as required by the Division or AHCCCS. In such cases, qualified personnel must be used to collect data and the AdSS must ensure inter-rater reliability if more than one person is collecting and entering data. The AdSS must submit specific documentation as requested by the Division, to verify that indicator criteria were met.

H. AdSS rates for each measure will be compared with the MPS specified in the contract in effect during the applicable measurement period.
980 PERFORMANCE IMPROVEMENT PROJECTS

EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR 438.330, Section F3, Contractor Chart of Deliverables
DELIVERABLES: Performance Improvement Project (PIP) Reports – Baseline, Intervention, or Re-measurement based on applicable reporting year; Performance Improvement Project (PIP) Reports – Final; Performance Improvement Project (PIP) Reports –as Requested

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

Overview

The Administrative Services Subcontractors (AdSS) of the Division of Developmental Disabilities (Division) must participate in Performance Improvement Projects (PIPs) selected by the Division and AHCCCS. The AdSS may also select and design, with Division approval, additional PIPs specific to needs identified through internal monitoring of trends and data. Topics take into account comprehensive aspects of member’s needs, care, and services for a broad spectrum of members or a focused subset of the population. When developing quality assessment and PIPs, the Division and its AdSS must consider all populations and services covered when selecting PIPs.

The Division may also mandate that a PIP be conducted by an AdSS according to standardized methodology.

The Centers for Medicare and Medicaid Services (CMS) in consultation with AHCCCS, states, and other stakeholders, specify standardized performance measures and topics for PIPs for inclusion with state-specified measures and topics in state contracts. The AdSS must participate in performance measures and PIPs that are mandated by CMS.

Performance Improvement Projects (PIPs) Design

A. PIPs are designed, through ongoing measurement and intervention, to achieve:

1. Demonstrable improvement, sustained over time, in significant aspects of clinical care and nonclinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction

2. Correction of significant systemic problems.

B. Clinical focus topics may include:

1. Primary, secondary, and/or tertiary prevention of acute conditions

2. Primary, secondary, and/or tertiary prevention of chronic conditions

3. Care of acute conditions

4. Care of chronic conditions

5. High-risk services
6. Continuity and coordination of care.

C. Nonclinical focus topics may include:
   1. Availability, accessibility, and adequacy of the Division’s service delivery system
   2. Cultural competency of services
   3. Interpersonal aspects of care (e.g., quality of provider/member encounters)
   4. Appeals, grievances, and other complaints.

D. Behavioral health topics may include:
   1. A change in behavioral health status or functional status
   2. A change in member satisfaction.

E. PIP methodologies are developed according to 42 CFR 438.330, Quality Assessment and Performance Improvement Programs for Medicaid Managed Care Organizations. The Division has adopted AHCCCS’s protocol for developing and conducting PIPs, see Attachment 980-A in the AHCCCS Medical Policy Manual.

Data Collection Methodology

Assessment of the AdSS’s performance on the selected measures will be based on systematic, ongoing collection and analysis of the most accurate, valid and reliable data, as collected and analyzed by the Division and AHCCCS. The AdSS may be directed to collect all or some of the data used to measure performance. The AdSS must ensure inter-rater reliability if more than one person is collecting and entering data. The AdSS must submit specific documentation to verify that indicator criteria were met.

Measurement of Demonstrable Improvement

A. The AdSS must initiate interventions that result in significant demonstrable improvement, sustained over time, in its performance for the performance indicators being measured. Improvement must be evidenced in repeated measurements of the indicators specified for each PIP undertaken by the AdSS.

B. The AdSS must meet benchmark levels of performance defined in advance by the Division or AHCCCS.

C. The AdSS will have demonstrated improvement when:
   1. It meets or exceeds the Division or AHCCCS’ overall average for the baseline measurement if its baseline rate was below the average and the increase is statistically significant.
   2. It shows a statistically significant increase if its baseline rate was at or above the Division or AHCCCS overall average for the baseline measurement, or
3. It is the highest performing (benchmark) plan in any remeasurement and maintains or improves its rate in a successive measurement.

D. The AdSS will have demonstrated sustained improvement when:
   
   1. The AdSS maintains or increases the improvements in performance for at least one year after the improvement in performance is initially achieved.
   
   2. The AdSS must demonstrate how the improvement can be reasonably attributable to the interventions undertaken by the organization.

**Performance Improvement Projects (PIPs) Timeframes**

A. The AdSS must initiate mandated PIPs on the date established by the Division or AHCCCS. Baseline data will be collected and analyzed at the beginning of the PIP.

B. During the initial year of a mandated PIP, the AdSS will implement interventions to improve performance, based on an evaluation of barriers to care/use of services and evidence-based approaches to improving performance, as well as any unique factors such as its membership, provider network, or geographic area(s) served. The Division or AHCCCS may provide baseline data, and may provide additional data by race/ethnicity, and/or geographic area, which may assist the AdSS in refining interventions.

C. The AdSS should use a Plan-Do-Study-Act (PDSA) cycle to test changes (interventions) quickly and refine them as necessary. The rapid cycle improvement process is implemented in as short a time frame as practical based on the PIP topic. (See description of PDSA cycle in Policy 970 in this Chapter.)

D. The Division conducts annual measurements to evaluate the AdSS performance, and may conduct interim measurements, depending on the resources required to collect and analyze data.

E. The AdSS’s participation in the mandated PIP will continue until demonstration of significant improvement is sustained for at least one year.

**Performance Improvement Projects (PIPs) Reporting Requirements**

A. Annually, the AdSS must report to the Division its interventions, analysis of interventions and internal measurements, changes or refinements to interventions and actual or projected results from repeat measurements.

B. The Division has adopted AHCCCS’s Performance Improvement Project (PIP) Report, Exhibit 980-B in the AHCCCS Medical Policy Manual. This template must be used to submit the annual reports, as specified in Section F3, Contractor Chart of Deliverables, which are due with the AdSS’s annual Quality Management Plan and Evaluation.
1000  CHAPTER DELIVERABLES

Deliverables specific to individual Policies are identified in those individual Policies.

Deliverables related to this Chapter as a whole include:

1. HIV Specialty Provider List
2. Non-Transplant and Catastrophic Reinsurance
3. Outpatient Commitment COT Monitoring
4. Pregnant Women and Post-Partum
5. Prescription Drug Utilization Report
6. Transplant Log
1010 MEDICAL MANAGEMENT ADMINISTRATIVE REQUIREMENTS

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. § 36-2907; A.A.C. R9-22-201 et seq.; 42 CFR 438.210(b)(3) and 406(a)(3); AMPM Appendix C Medical Management (MM) Plan Checklist and Appendix G Medical Management (MM) Work Plan Guide and Template; Section F3, Contractor Chart of Deliverables

DELIVERABLES: MM/UM Plan and Evaluation

The Division contracts with Administrative Services Subcontractors (AdSS) and delegates responsibility of implementation of this policy.

Medical Management Plan

A. The AdSS must develop a written Medical Management (MM) Plan that describes the methodology used to meet or exceed the standards and requirements of its contract with the Division and this Chapter.

B. The AdSS must submit the MM Plan, and any subsequent modifications, to the Division for review and approval prior to implementation. The AdSS must use AMPM Appendix C Medical Management (MM) Plan Checklist and Appendix G Medical Management (MM) Work Plan Guide and Template in the AHCCCS Medical Policy Manual, as adopted by the Division. Specific page numbers must be indicated on the checklist that specify where the required information can be found in the MM Plan narrative. The plan will not be accepted if the checklist is not included at the time of submission.

C. At a minimum, the MM Plan must describe, in detail, the MM program and how program activities assure appropriate management of medical care service delivery for enrolled members. MM Plan components must include:

1. A description of the AdSS’s administrative structure for oversight of its MM program as required by this policy, including the role and responsibilities of:
   a. The governing or policy-making body
   b. The MM committee
   c. The AdSS Executive Management
   d. MM program staff

2. An organizational chart that delineates the reporting channels for MM activities and the relationship to the AdSS Medical Director and Executive Management

3. Documentation that the governing or policy-making body has reviewed and approved the MM Plan

4. Documentation that appropriately qualified, trained and experienced personnel are employed to effectively carry out MM program functions and
meet qualification required by this policy

5. The AdSS’s specific MM goals and measurable objectives as required by Division’s Medical Policy Manual, Policy 1020.

6. Documentation of how the following processes are implemented and monitored to ensure quality and cost-effective care is provided to members in compliance with state and federal regulations:
   a. MM Utilization Data Analysis and Data Management
   b. Concurrent Review
   c. Discharge Planning
   d. Prior Authorization
   e. Inter-Rater Reliability
   f. Retrospective Review
   g. Clinical Practice Guidelines
   h. New Medical Technologies and New Uses of Existing Technologies
   i. Case Management/Care Coordination
   j. Disease/Chronic Care Management
   k. Drug Utilization Review

7. The AdSS’s method(s) for monitoring and evaluating its service delivery system and provider network that demonstrates compliance with Division’s Medical Policy Manual, Policy 1020

8. A description of how delegated activities are integrated into the overall MM program and the methodologies for oversight and accountability of all delegated functions, as required by this policy

9. Documentation of input into the medical coverage policies from the AdSS or affiliated providers and members

10. A summary of the changes made to the AdSS’s list of services requiring prior authorization and the rationale for those changes.
**MM Work Plan**

The AdSS is responsible for developing a work plan that identifies the goals, methodology for improvement, and monitoring efforts related to the MM program requirements outlined in Division’s Medical Policy Manual, Policy 1020 in this Manual. The work plan must:

A. Be submitted in an acceptable format on the template adopted by the Division and provided by AHCCCS

B. Support the MM Plan goals and objectives

C. Include goals that are quantifiable and reasonably attainable

D. Include specific actions for improvement

E. Incorporate a Plan, Do, Study, Act (PDSA) methodology for testing an action designed to result in a desired improvement in a specific area. Refer to Policy 970 of this Policy Manual for details related to PDSA methodologies.

**MM Evaluation**

A. An annual narrative evaluation of the effectiveness of the previous year's MM strategies and activities must be submitted to the Division after being reviewed and approved by the AdSS’s governing or policy-making body. The narrative summary of the previous year's work plan must include but is not limited to:

1. A summary of the MM activities performed throughout the year with:

   a. Title/name of each activity
   b. Desired goal and/or objective(s) related to each activity
   c. Staff positions involved in the activities
   d. Trends identified and the resulting actions implemented for improvement
   e. Rationale for actions taken or changes made
   f. Statement describing whether the goals/objectives were met.

2. Review, evaluation, and approval by the MM Committee of any changes to the MM Plan

3. Necessary follow-up with targeted timelines for revisions made to the MM Plan.

B. The MM Plan and MM Evaluation may be combined or written separately, as long as required components are addressed and easily located.

C. Refer to Section F3, Contractor Chart of Deliverables for reporting requirements and timelines.
MM Administrative Oversight

A. The AdSS MM program must be administered through a clear and appropriate administrative structure. The governing or policy-making body must oversee and be accountable for the MM Program. AdSS must ensure ongoing communication and collaboration between the MM program and the other functional areas of the AdSS’s organization (e.g., quality management, member and provider services).

B. The AdSS must have an identifiable and structured MM Committee that is responsible for MM functions and responsibilities, or if the MM Committee is combined with the Quality Management Committee, the agenda items and minutes reflect that MM issues and topics are presented, discussed, and acted upon.

C. At a minimum, the membership must include:
   1. The Medical Director, or appointed designee, as the chairperson of the MM Committee
   2. The MM Manager
   3. Representation from the functional areas within the AdSS’s organization
   4. AdSS staff with experience with Developmental Disabilities, Behavior Health, and medically fragile physical health conditions.
   5. Representation of contracted or affiliated providers.

D. The Medical Director, as chairperson for the MM Committee, or his/her designee, is responsible for the implementation of the MM Plan and must have substantial involvement in the assessment and improvement of MM activities.

E. The MM Committee must ensure that each of its members is aware of the requirements related to confidentiality and conflicts of interest (e.g., a signed statement on file or MM Committee sign-in sheets with requirements noted).

F. The frequency of MM Committee meetings must be sufficient to demonstrate that the MM Committee monitors all findings and required actions. At a minimum, the MM Committee must meet quarterly.

G. MM Committee meeting minutes must include the data reported to the MM Committee, and analysis and recommendations made by the MM Committee. Data, including utilization data, may be attached to the MM Committee meeting minutes as separate documents if the documents are noted in the MM Committee meeting minutes. Recommendations made by the MM Committee must be discussed at subsequent MM Committee meetings. The MM Committee must review the MM program objectives and policies annually and updates them as necessary to ensure:
   1. The MM responsibilities are clearly documented for each MM function/activity.
   2. The AdSS and their providers are informed of the most current MM requirements, policies and procedures in a timely fashion in order to allow for
implementation that does not adversely impact the members or provider community.

3. The AdSS and their providers are informed of information related to their performance (e.g., provider profiling data).

4. The MM policies and procedures, and any subsequent modifications to them, are available upon request by the Division.

H. The MM Program must be staffed with a sufficient number of appropriately qualified personnel to carry out the functions and responsibilities specified in this Chapter.

I. Staff qualifications for education, experience, and training must be developed for each MM position.

J. The grievance process must be part of the new hire and annual staff training, which includes:
   1. What constitutes a grievance
   2. How to report a grievance
   3. The role of the AdSS’s quality management staff in grievance resolution.

K. A current organizational chart is maintained to show reporting channels and responsibilities for the MM program.

L. The AdSS must maintain records that document MM activities, and it must make the information available to the Division upon request. The required documentation includes, but is not limited to:
   1. Policies and procedures
   2. Reports
   3. Practice guidelines
   4. Standards for authorization decisions
   5. Documentation resulting from clinical reviews (e.g. notes related to concurrent review, retrospective review, and prior authorization)
   6. Meeting minutes including analyses, conclusions, and actions required with completion dates
   7. Corrective Action Plans (CAPs) resulting from the evaluation of any component of the MM program such as inter-rater reliability
   8. Other information and data deemed appropriate to support changes made to the scope of the MM Plan.
M. The AdSS must have written policies and procedures pertaining to:

1. Verification that information/data received from providers is accurate, timely, and complete

2. Review of reported data for accuracy, completeness, logic, and consistency, (review and evaluation processes used must be clearly documented)

3. Security and confidentiality of all member and provider information protected by federal and state law

4. Informing of appropriate parties of the MM requirements and updates, utilization data reports, and profiling results.

5. Identification of provider trends and subsequent necessary corrective action regarding over/under utilization of services

6. Quarterly evaluations and trending of internal appeal overturn rates

7. Quarterly evaluations of the timeliness of service request decisions

8. Annual review of prior authorization requirements that encompasses the analysis of prior authorization decision outcomes, including but not limited to, the rationale for requiring prior authorization for types of services such as high dollar, high risk, or case finding for care management.

N. The AdSS must have processes that ensure:

1. Per 42 CFR 438.210(b)(3), qualified health care professionals, with appropriate clinical expertise in treating the enrollee’s condition or disease, render decisions to:
   a. Deny an authorization request based on medical necessity.
   b. Authorize a request in an amount, duration, or scope that is less than requested.
   c. Make a decision involving excluded or limited services under Arizona Revised Statute A.R.S. § 36-2907(B) and A.A.C. R9-22-201 et seq., as specified in this policy.

2. Per 42 CFR 438.406(a)(3), qualified health care professionals, with appropriate clinical expertise in treating the members’ condition or disease, and who have not been involved in any previous level of decision making, will render decisions regarding:
   a. Appeals involving denials based on medical necessity
   b. Grievances regarding denial of expedited resolution of an appeal
   c. Grievances and appeals involving clinical issues.
3. Prompt notifications to the requesting provider and the member or member’s authorized representative or Medical Power of Attorney, as applicable, of any decision to deny, limit, or discontinue authorization of services. The notice includes information as specified in the Division’s AdSS Operations Manual.

4. For purposes of this section, the following qualified health care professionals have the appropriate clinical expertise to render decisions based on previously established Division contractor standards and clinical criteria for skilled and non-skilled services within their scope of practice:
   a. Physician
   b. Podiatrist
   c. Optometrist
   d. Chiropractor
   e. Psychologist
   f. Dentist
   g. Physician assistant
   h. Physical or occupational therapist
   i. Speech-language pathologist
   j. Audiologist
   k. Registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife)
   l. Licensed social worker
   m. Registered respiratory therapist
   n. Licensed marriage and family therapist
   o. Licensed professional counselor.

5. Decision-making includes determinations involving excluded or limited services under A.R.S. § 36-2907 and A.A.C. R9-22-201 et seq.

6. Consistent application of standards and clinical criteria, and ensure consistent decisions that include inter-rater reliability criteria and monitoring of all staff involved in this process. A plan of action must be developed and implemented for staff who fail to meet the inter-rater reliability standards.
O. The AdSS must maintain a health information system that collects, integrates, analyzes, and reports data necessary to implement its MM Program. Data elements must include but are not limited to:

1. Member demographics
2. Provider characteristics
3. Services provided to members
4. Other information necessary to guide the selection of, and meet the data collection requirements for, improvement activities.

P. The AdSS must oversee and maintain accountability for all functions or responsibilities described in this Chapter that are delegated to other entities. Documentation must be kept on file, for Division review, and the documentation must demonstrate and confirm the following requirements have been met for all delegated functions:

1. A written agreement must be executed that specifies the delegated activities and reporting responsibilities of the entity to the AdSS and include provisions for revocation of the delegation or imposition of sanctions for inadequate performance.
2. The AdSS must evaluate the entity’s ability to perform the delegated activities prior to executing a written agreement for delegation. The delegated agreement must be submitted the contractor review checklist adopted by the Division and located in the AHCCCS Contractor Operations Manual.
3. The performance of the entity and the quality of services provided are monitored on an ongoing basis and formally reviewed.

Q. The AdSS must ensure:

1. Compensation to persons or organizations conducting prior or prospective authorization, and concurrent or retrospective review activities are not structured so as to provide inappropriate incentives for selection, denial, limitation or discontinuation or authorization of services.
2. Providers are not prohibited from advocating on behalf of members within the service provision process.
1020 MEDICAL MANAGEMENT (MM) SCOPE AND COMPONENTS

EFFECTIVE DATE: October 1, 2019
DELIVERABLES: Adult and Child Emergency Department (ED) Wait Times; Diabetic Diagnosis Report; Emergency Department Diversion Summary; Inappropriate Emergency Department (ED) Utilization Report; Inpatient Hospital Showings Report; Members in Need of Care Manager; Notification of All Hospital Admissions; Pressure Ulcer Report; Psychiatric Security Review Board (PSRB)/Guilty Except Insane (GEI) Conditional Release Report

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). This policy outlines requirements for the AdSS to develop an integrated process or system that is designed to assure appropriate use of health care resources, in the amount and duration necessary to achieve desired health outcomes, across the continuum of care from prevention to hospice, including Advanced Care Planning at any age or stage of illness.

Definitions

A. Advance Care Planning - Advance care planning is a part of the End of Life care concept and is a billable service that is a voluntary face-to-face ongoing discussion between a qualified health care professional and the member to:

1. Educate the member/guardian/designated representative about the member’s illness and the health care options that are available to them.

2. Develop a written plan of care that identifies the member’s choices for treatment.

3. Share the member’s wishes with family, friends, and his or her physicians.

B. Arizona State Hospital (AZSH) - Provides long-term inpatient psychiatric care to Arizonans with mental illnesses who are under court order for treatment.

C. Autism Spectrum Disorder - Autism spectrum disorder (ASD) is a developmental disability that can cause significant social, communication and behavioral challenges.

D. Conditional Release Plan (CRP) - If the psychiatric security review board finds that the person still suffers from a mental disease or defect or that the mental disease or defect is in stable remission but the person is no longer dangerous, the board must order the person's conditional release. The person must remain under the board's jurisdiction. The board in conjunction with the state mental health facility and behavioral health community providers must specify the conditions of the person's release. The board must continue to monitor and supervise a person who is released conditionally. Before the conditional release of a person, a supervised treatment plan must be in place, including the necessary funding to implement the plan as outlined in A.R.S. § 13.3994.
E. **Emergency Medical Condition** - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

1. Placing the patient’s health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part [42 CFR 438.114(a)].

F. **End-of-Life Care -** A concept of care, for the duration of the member’s life, that focuses on Advance Care Planning, the relief of stress, pain, or life limiting effects of illness to improve quality of life for a member at any age who is currently or is expected to experience declining health, or is diagnosed with a chronic, complex or terminal illness.

G. **Health Care Acquired Condition (HCAC)** - A Hospital Acquired Condition (HAC) under the Medicare program, with the exception of Deep Vein Thrombosis/Pulmonary Embolism following total knee or hip replacement for pediatric and obstetric patients, which occurs in any inpatient hospital setting and which is not present on admission.

H. **Lennox-Gastaut Syndrome** - A progressive disorder that includes refractory seizures, cognitive decline, and functional and behavioral deterioration.

I. **Medication Assisted Treatment (MAT)** - The use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of substance use disorders and can help some people to sustain recovery.

J. **Other Provider-Preventable Condition (OPPC)** - A condition occurring in the inpatient and outpatient health care setting which AHCCCS has limited to the following:

1. Surgery on the wrong member
2. Wrong surgery on a member
3. Wrong site surgery.

K. **Practical Support** - Non-billable services provided to a member by a family member, friend or volunteer to assist or perform functions such as, but not limited to; housekeeping, personal care, food preparation, shopping, pet care, or non-medical comfort measures.

L. **Psychiatric Security Review Board (PSRB)** - The psychiatric security review board is established consisting of the following members who are appointed by the governor pursuant to A.R.S. § 38-211 as outlined in A.R.S. § 31-501 experienced in the criminal justice system:

1. One psychiatrist
2. One psychologist
3. One person who is experienced in parole, community supervision or probation procedures
4. One person who is from the general public
5. One person who is either a psychologist or a psychiatrist.

M. Vivitrol - An opioid antagonist that blocks opioid receptors in the brain for one month at a time, helping patients to prevent relapse to opioid dependence, following detoxification, while they focus on counseling and treatment.

Utilization Data Analysis and Data Management

The AdSS must have in effect mechanisms to review utilization and detect both underutilization and overutilization of services [42 CFR 438.240(b)(3)]. The AdSS must develop and implement processes to collect, validate, analyze, monitor, and report the utilization data. On an ongoing basis, the AdSS’s Medical Management (MM) Committee must review and evaluate the data findings and make or approve recommendations for implementing actions for improvement when variances are identified. Evaluation must include a review of the impact to both service quality and outcome. The MM Committee must determine, based on its review, if action (new or changes to current intervention) is required to improve the efficient utilization of health care services. Intervention strategies to address overutilization and underutilization of services must be integrated throughout the organization. All such strategies must have measurable outcomes that are reported in AdSS MM Committee minutes.

For ASD: This measure is used to assess the combined number of child and adolescent psychiatrists, neurodevelopmental pediatricians, and developmental-behavioral pediatricians who have provided any outpatient care to at least one enrolled child, per 1,000 eligible children.

The quarterly deliverable will be a rate that will be expressed in terms of 1,000 eligible children (number of providers/1,000 enrolled children). The eligible population includes children younger than 18 years of age who have been enrolled in a Medicaid program or health plan that includes outpatient specialty care for at least one 90-day period (or 3 consecutive months) within the measurement year and classified to counties of Arizona. Taxonomy codes identify specialists: Child and Adolescent Psychiatrist (2084P0804X), Neurodevelopmental Pediatricians (2080P0008X) and Developmental-Behavioral Pediatricians (2080P0006X). The deliverable will be used to identify critical gaps for effective recognition and treatment for these specific providers.

For Lennox-Gastaut Syndrome: This deliverable is used to collect data on seizure type/syndrome classification which is salient for quality treatment through early identification for those with epilepsy. Infantile spasms are at higher risk to developing Lennox-Gastaut syndrome connected with intellectual disability.

Reportable data to be reported quarterly will be obtained from the population which includes children younger than 18 years of age who have been enrolled in a Medicaid program or health plan that includes outpatient specialty care for at least one 90-day period (or 3
consecutive months) within the measurement year and classified to counties of Arizona. Members meeting this criterion will be identified by the ICD-10 codes for Infantile Spasms (G40.822) and Lennox-Gastaut Syndrome (G40.812).

**Concurrent Review**

The AdSS must have policies, procedures, processes, and criteria in place that govern the use of services in institutional settings. The AdSS must have procedures for review of medical necessity before a planned institutional admission (precertification) and for determination of the medical necessity for ongoing institutional care (concurrent review).

A. Policies and procedures for the concurrent review process must:

1. Include relevant clinical information when making hospital length of stay decisions. Relevant clinical information may include but is not limited to symptoms, diagnostic test results, diagnoses, and required services.

2. Specify timeframes and frequency for conducting concurrent review and decisions:
   a. Authorization for institutional stays that will have a specified date by which the need for continued stay will be reviewed
   b. Admission reviews must be conducted within one business day after notification is provided to the AdSS by the hospital or institution (this does not apply to pre-certifications) (42 CFR 456.125)

3. Provide a process for review that includes but is not limited to:
   a. Necessity of admission and appropriateness of the service setting
   b. Quality of care
   c. Length of stay
   d. Whether services meet the member needs
   e. Discharge needs
   f. Utilization pattern analysis.

4. Establish a method for the AdSS’s participation in the proactive discharge planning of all members in institutional settings.

B. Criteria for decisions on coverage and medical necessity must be clearly documented and based on reasonable medical evidence or a consensus of relevant health care professionals.

1. Medical criteria must be approved by the AdSS’s MM Committee. Criteria must be adopted from national standards. When providing concurrent review, the AdSS must compare the member's medical information against medical necessity criteria that describes the condition or service.
2. Initial institutional stays are based on the AdSS’s adopted criteria, the member’s specific condition, and the projected discharge date.

3. Continued stay determinations are based on written medical care criteria that assess the need for the continued stay. The extension of a medical stay will be assigned a review date each time the review occurs. The AdSS ensures that each continued stay review date is recorded in the member’s record.

4. The AdSS concurrent review staff must coordinate with the inpatient facility’s Utilization Review Department and Business Office, when there is any change to the CRS authorization status or level of care required for CRS members.

5. The AdSS concurrent review staff must notify the AIHP, or DDD concurrent review staff when they become aware that a member who receives CRS is admitted to the hospital.

6. Conversely, the Division’s concurrent review staff will notify the AdSS’s concurrent review staff when they become aware that a member eligible for CRS services is admitted to the hospital.

7. Coordination will include proactive discharge planning between all potential payment and care sources upon completion of the CRS related service, and

8. AdSS must submit the “Contractor Quarterly Showing Report for Inpatient Hospital Services” as specified in Contract. Confirming there were methods and procedures in place as required.

**Discharge Planning**

The AdSS must have policies and procedures in place that govern the process for proactive discharge planning and coordinating services the ADSS furnishes to the member between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays.

The intent of the discharge planning policy and procedure is to increase the management of inpatient admissions, improve the coordination of post discharge services, reduce unnecessary hospital stays, ensure discharge needs are met, and decrease readmissions within 30 days of discharge. The AdSS must develop and implement a discharge planning process that ensures members receiving inpatient services have proactive discharge planning to identify and assess the post-discharge bio-psychosocial and medical needs of the member in order to arrange necessary services and resources for appropriate and timely discharge from a facility. A proactive assessment of discharge needs must be conducted before admission when feasible. Discharge planning must be performed by a qualified healthcare professional and initiated on the initial concurrent review, updated periodically during the inpatient stay, and continued post discharge to ensure a timely, effective, safe and appropriate discharge.

The AdSS staff participating in the discharge planning process must ensure the member/guardian/ designated representative, as applicable:

A. Is involved and participates in the discharge planning process
B. Understands the written discharge plan, instructions and recommendations provided by the facility

C. Is provided resources, referrals and possible interventions to meet the member’s assessed and anticipated needs after discharge.

Discharge planning, coordination and management of care must include:

A. Follow-up appointment with the PCP and/or specialist within 7 days
B. Safe and clinically appropriate placement, and community support services
C. Communication of the member’s treatment plan and medical history across the various outpatient providers, including the member’s outpatient clinical team, TRBHA and other contractor when appropriate
D. Prescription medications
E. Medical Equipment
F. Nursing Services
G. End of Life Care related services such as Advance Care Planning
H. Practical supports
I. Hospice
J. Therapies (There are limits for outpatient physical therapy visits for members 21 years of age and older. See Policy 310-X in this Policy Manual.)
K. Referral to appropriate community resources
L. Referral to AdSS’s Disease Management or Care Management (if needed)
M. A post discharge follow-up call to the member within three days of discharge to confirm the member’s well-being and the progress of the discharge plan according to the member’s assessed clinical, behavioral, physical health, and social needs
N. Additional follow-up actions as needed based on the member’s needs
O. Proactive discharge planning when the AdSS is not the primary payer.

Prior Authorization and Service Authorization

The AdSS must have an Arizona-licensed prior authorization staff that includes a nurse or nurse practitioner, physician or physician assistant, pharmacist or pharmacy technician, or licensed behavioral health professional with appropriate training, to apply the AdSS’s medical criteria or make medical decisions.

Prior authorization is required in certain circumstances.
The AdSS must develop and implement a system that includes at least two modes of delivery for providers to submit prior authorization requests such as telephone, fax, or electronically through a portal on the AdSS’s website.

The AdSS must ensure providers who request authorization for a service are notified that they have the option to request a peer to peer discussion with the AdSS Medical Director when additional information is requested by the AdSS or when the prior authorization request is denied. The AdSS must coordinate the discussion with the requesting provider when appropriate.

The AdSS must develop and implement policies and procedures, coverage criteria and processes for approval of covered services, which include required time frames for authorization determination.

A. Policies and procedures for approval of specified services must:

1. Identify and communicate, to providers, TRBHAs and members, those services that require authorization and the relevant clinical criteria required for authorization decisions. Services not requiring authorization must also be identified. Methods of communication with members include newsletters, AdSS website, and/or member handbook. Methods of communication with providers and TRBHAs include newsletters, AdSS website, and/or provider manual. Changes in the coverage criteria must be communicated to members, TRBHAs and providers 30 days before implementation of the change.

2. Delineate the process and criteria for initial authorization of services and/or requests for continuation of services. Criteria must be made available to providers and TRBHAs through the provider manual and AdSS website. Criteria must be available to members upon request.

3. Authorize services in a sufficient amount, duration, or scope to achieve the purpose for which the services are furnished.

4. Ensure consistent application of review criteria.


6. Provide decisions and notice as expeditiously as the member’s health condition requires and no later than 72-hours after receipt of an expedited service request pursuant to 42 CFR 438.210(d)(2)(i).

7. Provide for consultation with the requesting provider when appropriate.

8. Review all prior authorization requirements for services, items, or medications annually. The review will be reported through the MM Committee and will include the rationale for changes made to prior authorization requirements. A summary of the prior authorization requirement changes and the rationale for
those changes must be documented in the MM Committee meeting minutes.

B. AdSS must develop and implement policies for processing and making determinations for prior authorization requests for medications. The AdSS must ensure the following:

1. A decision to a submitted prior authorization request for a medication is provided by telephone, fax, electronically or other telecommunication device within 24 hours of receipt of the submitted request for prior authorization,

2. A request for additional information is sent to the prescriber by telephone, fax, electronically or other telecommunication device within 24 hours of the submitted request when the prior authorization request for a medication lacks sufficient information to render a decision. A final decision must be rendered within seven business days from the initial date of the request,

3. At least a 4-day supply of a covered outpatient prescription drug is provided to the member in an emergent situation. [42 CFR 438.3(s)(6)].

C. The AdSS Criteria for decisions on coverage and medical necessity for both physical and behavioral services must be clearly documented, based on reasonable medical evidence or a consensus of relevant health care professionals.

1. The AdSS may not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary service solely because of the setting, diagnosis, type of illness or condition of the member.

2. The AdSS may place appropriate limits on services based on a reasonable expectation that the amount of service to be authorized will achieve the expected outcome.

3. The AdSS must have criteria in place to make decisions on coverage when the AdSS receives a request for service involving Medicare or other party payers. The fact that the AdSS is the secondary payer does not negate the AdSS’s obligation to render a determination regarding coverage within the timeframes established in this policy.

**Inter-rater Reliability**

The AdSS must have in place a process to ensure consistent application of review criteria in making medical necessity decisions which include prior authorization, concurrent review, and retrospective review. Inter-rater reliability testing of all staff involved in these processes must be done at least annually. A corrective action plan must be included for staff that do not meet the minimum compliance goal of 90%.
Retrospective Review

The AdSS must conduct a retrospective review, which is guided by the following.

A. Policies and procedures
   1. Include the identification of health care professionals with appropriate clinical expertise who are responsible for conducting retrospective reviews.
   2. Describe services requiring retrospective review.
   3. Specify time frame(s) for completion of the review.

B. Criteria for decisions on medical necessity must be clearly documented and based on reasonable medical evidence or a consensus of relevant health care professionals.

C. A process for consistent application of review criteria

D. Guidelines for Provider-Preventable Conditions

Title 42 CFR Section 447.26 prohibits payment for services related to Provider-Preventable Conditions. Provider-Preventable Condition means a condition that meets the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC). These terms are defined as follows:

A member’s health status may be compromised by hospital conditions and/or medical personnel in ways that are sometimes diagnosed as a “complication.” If it is determined that the complication resulted from an HCAC or OPPC, any additional hospital days or other additional charges resulting from the HCAC or OPPC will not be reimbursed.

If it is determined that the HCAC or OPPC was a result of a mistake or an error by a hospital or medical professional, the AdSS must conduct a quality of care investigation and report the occurrence and results of the investigation to the Division’s Quality Management Unit and the AHCCCS’ Clinical Quality Management Unit.

Clinical Practice Guidelines

A. The AdSS must develop or adopt and disseminate practice guidelines for physical and behavioral health services that:
   1. Are based on valid and reliable clinical evidence or a consensus of health care professionals in that field
   2. Consider the needs of the AdSS’s members
   3. Are either:
      a. Adopted in consultation with contracting health care professionals and National Practice Standards, or
b. Developed in consultation with health care professionals and include a thorough review of peer-reviewed articles in medical journals published in the United States when national practice guidelines are not available. Published peer-reviewed medical literature must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results and with positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.

4. Are disseminated by the AdSS to all affected providers and, upon the request, to members and potential members

5. Provide a basis for consistent decisions for utilization management, member education, coverage of services, and any other areas to which the guidelines apply (42 CFR 438.236).

B. The AdSS must annually evaluate the practice guidelines through a MM multi-disciplinary committee to determine if the guidelines remain applicable, represent the best practice standards, and reflect current medical standards.

C. The AdSS must document the review and adoption of the practice guidelines as well as the evaluation of efficacy of the guidelines.

New Medical Technologies and New Uses of Existing Technologies

A. The AdSS must develop and implement written policies and procedures for evaluating new technologies and new uses of existing technology. The policies and procedures must include the process and timeframe for making a clinical determination when a time sensitive request is made. A decision in response to an urgent request must be made as expeditiously as the member’s condition warrants and not later than 72 hours from receipt of request.

B. The AdSS must include coverage decisions by Medicare intermediaries and carriers, national Medicare coverage decisions, and Federal and State Medicaid coverage decisions.

C. The AdSS must evaluate peer-reviewed medical literature published in the United States. Peer-reviewed medical literature must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale.
D. The AdSS must establish:

1. Coverage rules, practice guidelines, payment policies, policies and procedures, utilization management, and oversight that allows for the individual member’s medical needs to be met

2. A process for change in coverage rules and practice guidelines based on the evaluation of trending requests. Additional review and assessment is required if multiple requests for the same technology or application of an existing technology are received.

3. A process for documenting the coverage determinations and rationale in the Medical Management Committee meeting minutes.

Care Coordination

The AdSS must establish a process to ensure coordination of member physical and behavioral health care needs across the continuum based on early identification of health risk factors or special care needs, as defined by the AdSS. Coordination must ensure the provision of appropriate services in acute, home, chronic, and alternative care settings that meet the member’s needs in the most cost-effective manner available.

AdSS care managers are expected to have direct contact with members for the purpose of providing information and coordinating care, but they are not performing the day-to-day duties of the assigned Support Coordinator. AdSS care management must occur at the MCO level or TRBHA level and cannot be delegated down to the provider level. AdSS care management is an administrative function.

Care managers identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health care outcomes. AdSS care managers work closely with assigned Support Coordinator to ensure the most appropriate plan and services for members.

The AdSS must develop a plan outlining short- and long-term strategies for improving care coordination using the physical and behavioral health care data available for members with behavioral health needs. In addition, the AdSS must develop an outcome measurement plan to track the progress of the strategies. The plan outlining the strategies for improving care coordination and the outcome measurement must be reported in the annual MM Plan, Evaluation and Work Plan submitted to the Division as specified in contract.

A. AdSS must establish policies and procedures that reflect integration of services to ensure continuity of care by:

1. Ensuring that, in the process of coordinating care, each member’s privacy is protected in accordance with the privacy requirements including, but not limited to, [45 CFR Parts 160 and 164, Subparts A and E], Arizona statutes and regulations, and to the extent that they are applicable [42 CFR 438.208 (b)(2) and (b)(4) and 438.224]

2. Allowing each member to select a Primary Care Provider (PCP) who is formally designated as having primary responsibility for coordinating the member’s
overall health care, and a behavioral health provider, if appropriate

3. Ensuring each member has an ongoing source of care appropriate to his or her needs 438.208(b)(1)

4. Ensuring each member receiving care coordination has a person or entity that is formally designated as primarily responsible for coordinating services for the member, such as the assigned Support Coordinator

The member must be provided information on how to contact their designated person or entity [438.208(b)(1)].

5. Specifying under what circumstance services are coordinated by the AdSS, including the methods for coordination and specific documentation of these processes

6. Coordinating the services for members between settings of care including appropriate discharge planning for short-term and long-term hospital and institutional stays [42 CFR 438.208(b)(2)(i)]

7. Coordinating covered services with the services the member receives from another contractor and/or FFS [42 CFR 438.208(b)(2)(ii) and (iii)]

8. Coordinating covered services with community and social services that are generally available through contracting or non-contracting providers, in the AdSS’s service area

9. Ensuring members receive End of Life Care and Advance Care Planning as specified in Policy 310-HH in this Policy Manual

10. Establishing timely and confidential communication of clinical information among providers, as specified in this Policy Manual

This includes the coordination of member care between the PCP, AdSS, and Tribal Regional Behavioral Health Authority (TRBHA) providers. At a minimum, the PCP must communicate all known primary diagnoses, comorbidities, and changes in condition to the AdSS or TRBHA providers when the PCP becomes aware of the AdSS or TRBHA provider’s involvement in care.

11. Ensuring the AdSS are providing pertinent diagnoses and changes in condition to the PCP in a timely manner

The AdSS must facilitate this communication exchange as needed and establish monitoring activities such as record review to ensure that the exchange occurs as follows:

   a. “Urgent” – Requests for intervention, information, or response within 24 hours

   b. “Routine” – Requests for intervention, information, or response within 10 days.
12. Educating and communicating with PCPs who treat any member with diagnoses of depression, anxiety or Attention Deficit Hyperactivity Disorder (ADHD) that care requirements include but are not limited to:
   a. Expectations described in “4” of this section
   b. Monitoring the member’s condition to ensure timely return to the PCP’s care for ongoing treatment, when appropriate, following stabilization by an AdSS.

13. Ensuring that behavioral health providers provide consultation to a member’s inpatient and outpatient treatment team and/or directly engage the member as part of the AdSS care management program.

14. Ensuring policies reflect care coordination for members presenting for care outside of the AdSS’s provider network.

15. Monitoring controlled and non-controlled medication. The AdSS must restrict members to an exclusive pharmacy or prescriber as specified in Policy 310-FF in the Policy Manual.

16. Meeting regularly with the AdSS to coordinate care for members with high behavioral and physical health needs and/or high costs.

   High level AdSS meetings must occur at least every other month or more frequently if needed to discuss barriers and outcomes. Care coordination meetings and staffing meetings must occur at least monthly or more as often as necessary to affect change. The AdSS must implement the following:
   a. Identification of High Need/High Cost members as required in contract
   b. Plan interventions for addressing appropriate and timely care for these identified members
   c. Report of outcome summaries to the Division, as specified in Section F3, Contractor Chart of Deliverables.

B. The AdSS must develop policies and implement procedures specific to members who are eligible for the Division, including:
   1. Identifying members with special health care needs
   2. Ensuring an assessment by an appropriate health care professional for ongoing needs of each member identified as having special health care needs or conditions
   3. Ensuring adequate care coordination among providers
   4. Ensuring a mechanism to allow direct access to a specialist as appropriate for the member’s condition and identified special health care needs (e.g., a standing referral or an approved number of visits).
C. The AdSS must implement measures to ensure that members receiving care Management:

1. Are informed of particular health care conditions that require follow-up
2. Receive, as appropriate, training in self-care and other measures they may take to promote their own health
3. Are informed of their responsibility to comply with prescribed treatments or regimens.

D. The AdSS must have in place a care management process whose primary purpose is the application of clinical knowledge to coordinate care needs for members who are medically, physically and/or behaviorally complex and require intensive medical and psychosocial support.

The AdSS must develop member selection criteria for care management model to determine the availability of services, and work with the member’s provider(s) or TRBHA. The care manager works with the assigned Support Coordinator, and TRBHA, PCP and/or specialist to coordinate and address member needs in a timely manner. The care manager must continuously document interventions and changes in the plan of care.

E. The AdSS care management individualized care plan will focus on achieving member wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation. The AdSS care manager must also assist the member in identifying appropriate providers, TRBHAs, and facilities throughout the continuum of services, while ensuring that available resources are being used in a timely and cost-effective manner in order to obtain optimum value for both the member and the AdSS.

The AdSS must provide oversight and monitoring of AdSS care management that is subcontracted or inclusive in a providers’ contractual agreement. The AdSS care management role must comply with all Division and AHCCCS requirements.

F. In addition to care coordination as specified in their contract with the Division, the AdSS must proactively provide care coordination for members who have multiple complaints regarding services or the AHCCCS Program. This includes members who do not meet the AdSS criteria for care management, as well as, members who contact governmental entities for assistance, including the Division and AHCCCS.

The AdSS must identify and coordinate care for members with Opioid Use Disorders and ensure access to appropriate services such as MAT and Peer Support Services.

G. The AdSS must develop and implement policies and procedures to provide high touch care management or other behavioral health and related services to members on Conditional Release from the Arizona State Hospital (AzSH) consistent with the Conditional Release Plan (CRP) issued by the Psychiatric Security Review Board PSRB, including but not limited to assignment to a AdSS care manager. The AdSS may not delegate the care management functions to a subcontracted provider.
The AdSS care manager is responsible for at minimum the following:

1. Coordination with AzSH for discharge planning,
2. Participating in the development and implementation of Conditional Release Plans,
3. Participation in the modification of an existing or the development of a new Individual Service Plan (ISP) that complies with the Conditional Release Plan (CRP),
4. Member outreach and engagement to assist the PSRB in evaluating compliance with the approved CRP,
5. Attendance in outpatient staffing at least once per month, and
6. Care coordination of care with the member’s treatment team, assigned Support Coordinator, TRBHA, and providers of both physical and behavioral health services to implement the ISP and the CRP,
7. Routine delivery of comprehensive status reporting to the PSRB,
8. Attendance in a monthly conference call with Division Health Care Services,
9. If a member violates any term of his or her CRP, the AdSS must immediately notify the PSRB and provide a copy to the Division and AzSH, and
10. The AdSS further agrees and understands it must follow all obligations, including those stated above, applicable to it as set forth in A.R.S. § 13-3994.

Any violation of the Conditional Release, psychiatric decompensation or use of alcohol, illegal substances or prescription medications not prescribed to the member must be reported to the PSRB and the AzSH immediately.

The AdSS must submit a monthly comprehensive status report for members on Conditional Release to the PSRB and Division Health Care Services, as specified in Contract using AHCCCS Medical Policy Manual (AMPM) Attachment 1020-A. The AdSS must provide additional documentation at the request of the Division’s Health Care Services. If a member’s mental status renders him/her incapable or unwilling to manage his/her medical condition and the member has a skilled medical need, the AdSS must arrange ongoing medically necessary nursing services in a timely manner.

H. The AdSS must identify and track members who use Emergency Department (ED) services inappropriately four or more times within a six-month period. Interventions must be implemented to educate the member on the appropriate use of the ED and divert members to the right care in the appropriate place of service.

AdSS care management interventions to educate members should include, but are not limited to:
1. Outreach phone calls/visits
2. Educational Letters
3. Behavioral Health referrals
4. High Need/High Cost Program referrals
5. Disease Management referrals

The AdSS must submit the bi-annual ED Diversion Report to the Division as specified in Contract. The report must identify the number of times the AdSS intervenes with members.

I. The AdSS must monitor the length of time adults and children wait to be discharged from the Emergency Department (ED) while awaiting behavioral health placement or wrap around services. Immediately upon notification that a member who needs behavioral health placement or wrap around services is in the ED, the AdSS must coordinate care with the ED and the member’s treatment team including the assigned Support Coordinator to discharge the member to the most appropriate placement or wrap around services. Additionally, the AdSS must submit the Adult and Child ED Wait Times Report using AMPM Attachment 1020-B as required in the AdSS Contract, Section F3, Contractor Chart of Deliverables.

J. The Division will lead reach-in care coordination efforts due to the low volume of members with justice system involvement. However, the Contractor is required to assist the Division in justice system “reach-in” care coordination efforts as directed by the Division. Reach-in care coordination activities are conducted for members who have been incarcerated in the adult correctional system for 30 days or longer, and have an anticipated release date. The Division initiates reach-in care coordination activities, with the assistance of the Contractor, when notified of a member’s anticipated release date. The Contractor’s care management protocols for members involved in reach-in care coordination shall be consistent with the Division’s Medical Policy Manual, Chapter 500.

The Contractor must notify the Division upon becoming aware that a member may be an inmate of a public institution when the member’s enrollment has not been suspended. The Division adjusts eligibility dates based upon AHCCCS’ notification of incarceration in AHCCCS’ 834 files sent to the Division, and capitation is adjusted as specified in Contract. In addition to the care coordination requirements, the Contractor shall also utilize the renewal date information to identify incarcerated members that may have missed their eligibility redetermination date while incarcerated causing a discontinuance of benefits and provide assistance with reapplication for AHCCCS Medical Assistance upon release.

K. The AdSS must develop policies and processes to collaborate with the Arizona Department of Corrections (ADC) in Maricopa County to provide care management to members enrolled in the Governor’s Vivitrol Treatment Program, as required by Executive Order 2017-01. The Vivitrol treatment program will only be initiated for
individuals being released from prison to Maricopa County. Individuals who have been determined eligible for Vivitrol treatment will receive a monthly injection of Vivitrol for up to 12 months to treat opioid dependence. Vivitrol will not be prescribed to pregnant or breast feeding women.

The AdSS must designate a care manager to provide care management to members enrolled in the Vivitrol treatment program.

Upon notification from the ADC Reentry Planner that a member is enrolled in the program and will be released in 30 days, the designated AdSS care manager will collaborate with the Reentry Planner and the ADC provider to determine the member’s appropriateness for participation in the Vivitrol treatment program. To qualify for entry into the program individuals must be eligible for Medicaid, commit to participate in the program both pre and post release and sign necessary releases of information and consent to participate, as well as:

1. Have a history of opioid dependence.
2. Be identified as a potential candidate for the program at least 30 days before release.
3. Commit to participate in substance use counseling pre and post release and Medication Assisted Treatment (MAT).
5. Pass urinalysis tests.
6. Pass the Naloxone challenge test (to be done three to seven days before first injection).
7. Be screened for physical and/or behavioral health comorbidities that may make the member ineligible for Vivitrol.
8. Be free from any medical conditions which contraindicate participation.
9. Be administered the Vivitrol two to three days before release.
10. Be released to the community under either county or ADC community supervision.
11. Be released to Maricopa County.

The AdSS care manager must also:

1. Confirm that the member received pre-release counseling and is scheduled for post release counseling and MAT related to Vivitrol treatment from the ADC provider.
2. Coordinate the referral with the MAT specialist who has agreed to prescribe and administer the post-release Vivitrol.
3. Provide accessibility to Naloxone and substance use treatment. Naloxone will be provided to whoever supports the member. If the member has no formal or informal support, the Naloxone will be provided directly to the member with instructions for the purpose and use by the provider within 72 hours following release from incarceration.

4. Act as a liaison between the ADC provider responsible for administering the first injection of Vivitrol and the MAT specialist.

5. Schedule a post release appointment with the MAT specialist within seven days of administration of last injection.

6. Schedule counseling and other needed behavioral health services as applicable.

7. Support the MAT specialist in identifying an alternate treatment if Vivitrol is not the appropriate course of treatment.

The AdSS must submit a semi-annual Vivitrol Treatment Program Report to the Division as specified in Contract. The report must identify:

1. The name of the member participating in the program
2. The member’s ADC # and AHCCCS ID
3. The date of the member’s first injection
4. The date the member was released from prison
5. The name of the post release prescriber
6. First appointment and then track monthly appointment (Received second shot and engaged in treatment in the first month)
7. Length of stay in treatment (e.g., end date)
8. Vivitrol end date and reason
9. If member decides to change medication
10. Compliance with treatment (e.g., regular drug screens)
11. Report on data monthly
12. Member satisfaction
13. Overdose/death and reason
14. Successfully completed their term of supervision
15. Recidivism
16. Positive drug screen
17. Emergency department
18. Hospital admission.

**AdSS Disease/Chronic Care Management**

The AdSS must implement a Disease/Chronic Care Management Program that focuses on members with high risk and/or chronic conditions that have the potential to benefit from a concerted intervention plan. The goal of the Disease/Chronic Care Management Program is to increase member self-management and improve practice patterns of providers, thereby improving healthcare outcomes for members.

A. The AdSS’s MM Committee must focus on selected disease conditions (e.g., Diabetes, Pneumonia admissions/ER visits, or constipation admissions/ER visits) based on use of services, needs and trends, at risk population groups, and high volume/high cost conditions to develop the Disease Management Program.

B. The Disease Management Program must include, but is not limited to:

1. Members at risk or already experiencing poor health outcomes due to their disease burden
2. Health education that addresses the following:
   a. Appropriate use of health care services
   b. Health risk-reduction and healthy lifestyle choices including tobacco cessation
   c. Screening for tobacco use with the Ask, Advise, and Refer model and refer to the Arizona Smokers Helpline using the proactive referral process
   d. Self-care and management of health conditions, including wellness coaching
   e. Self-help programs or other community resources that are designed to improve health and wellness
   f. EPSDT services for members including education and health promotion for dental/oral health services
   g. Maternity care programs and services for pregnant women including family planning
3. Interventions with specific programs that are founded on evidence based guidelines
4. Methodologies to evaluate the effectiveness of programs including education specifically related to the identified members’ ability to self-manage their...
disease and measurable outcomes

5. Methods for supporting both the member and the provider in establishing and maintaining relationships that foster consistent and timely interventions and an understanding of and adherence to the plan of care

6. Components for providers include, but are not limited to:
   a. Education regarding the specific evidenced based guidelines and desired outcomes that drive the program
   b. Involvement in the implementation of the program
   c. Methodology for monitoring provider compliance with the guidelines
   d. Implementation of actions designed to bring the providers into compliance with the practice guidelines.

**Drug Utilization Review**

Drug Utilization Review (DUR) is a systematic, ongoing review of the prescribing, dispensing and use of medications. The purpose of DUR is to assure efficacious, clinically appropriate, safe, and cost-effective drug therapy to improve member health status and quality of care.

The AdSS must develop and implement a system, including policies and procedures, coverage criteria and processes for their DUR programs.

A. Criteria for decisions on coverage and medical necessity must be clearly documented and based on the scientific evidence and standards of practice that include, but are not limited to, peer-reviewed medical literature, outcomes research data, official compendia, or published practice guidelines developed by an evidence-based process.

B. AdSS must manage a DUR program that includes, but is not limited to:

1. Prospective review process for:
   a. All drugs before dispensing. This review process may be accomplished at the pharmacy using a computerized DUR system. The DUR system, at minimum, must be able to identify potential adverse drug interactions, drug-pregnancy conflicts, therapeutic duplication and drug-age conflicts
   b. All non-formulary drug requests.

2. Concurrent drug therapy of selected members to assure positive health outcomes

3. Retrospective drug utilization review process to detect patterns in prescribing, dispensing, or administration of medication and to prevent inappropriate use or abuse
The review process serves as a means of identifying and developing prospective standards and targeted interventions.

4. Pattern analyses that evaluates clinical appropriateness, over and underutilization, therapeutic duplication, drug-disease contraindication, drug-drug interaction, incorrect duration of drug treatment, clinical abuse or misuse, use of generic products and mail order medications

5. Provision for education of prescribers and AdSS professionals on drug therapy problems based on utilization patterns with the aim of improving safety, prescribing practices and therapeutic outcomes. The program must include a summary of the educational interventions used and an assessment of the effect of these educational interventions on the quality of care.
## Diabetic Quarterly Rpt

### Report Information

| Health Plan | AHCCCS ID | Consume r Name | DOB | PCP First Name | PCP Last Name | PCP Address 1 | PCP City | PCP Zip | PCP Phone Number | New Identification of Diabetes | ICD 10 Code identified in claims | Most Recent Hb A1c Result | Most Recent Hb A1c Date | Diabetes Medication 1 | Diabetes Medication 2 | Diabetes Medication 3 | Insulin Pen | Insulin Pump | Comments |
|-------------|-----------|----------------|-----|----------------|---------------|---------------|-----------|--------|----------------|-----------------------------|-------------------------------|------------------------|-----------------------|-----------------------|-----------------------|-----------------------|---------------------|-------------|-------------|----------|
|             |           |                |     |                |               |               |           |        |                |                             |                              |                        |                       |                       |                       |                       |                     |             |             |          |
**Emergency Department (ER) Diversion Reporting Tool**

**INSTRUCTIONS**

In accordance with SB 1034, please report total numbers in each category. This is not a member specific report.

It is expected that each member will have more than one intervention. The interventions listed above are not listed in order of occurrence or priority.

This report must be submitted bi-annually on October 15th and April 15th.

<table>
<thead>
<tr>
<th>Total Number of Members Utilizing ED Inappropriately 4 x in 6 months</th>
<th>Outreach Calls/Visits</th>
<th>Educational Letters</th>
<th>Referral to Behavioral Health</th>
<th>Referral to High Need/High Cost Program</th>
<th>Assignment to Exclusive Pharmacy</th>
<th>Disease Management</th>
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## Notification Of All Hospital Admissions

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<thead>
<tr>
<th>Member Last Name</th>
<th>Member First Name</th>
<th>AHCCCS ID #</th>
<th>DOB</th>
<th>Health Plan</th>
<th>Inpatient Facility Name</th>
<th>Level of Care (Type)</th>
<th>Admit Date</th>
<th>Discharge Date</th>
<th>Diagnosis 1</th>
<th>Diagnosis Code 1</th>
<th>Diagnosis 2</th>
<th>Diagnosis Code 2</th>
<th>Inpatient Days per Admission</th>
<th>Current Total Days</th>
<th>Medicare Y/N</th>
<th>TPL Y/N</th>
<th>HCS Nurse</th>
<th>Comments</th>
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<td>MM/YYYY</td>
<td>Member ID</td>
<td>Last Name</td>
<td>First Name</td>
<td>County</td>
<td>Diagnosis 1</td>
<td>Dx 1 Desc</td>
<td>Service Type 1</td>
<td>Service Type 2</td>
<td>Month</td>
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1050 COORDINATION OF CARE WITH OTHER GOVERNMENT ENTITIES FOR BEHAVIORAL HEALTH SERVICES

EFFECTIVE DATE: October 1, 2019

This policy applies to the Division’s Administrative Service Subcontractors (AdSSs). All coordination referenced in this policy applies to members eligible for the Division and ALTCS.

The Division requires the AdSS to coordinate services and communicate with other government entities, to ensure that members have proper access to care, optimal quality of service and coordination of care. This policy outlines requirements for the AdSS to establish and maintain collaborative relationships with these entities and to develop and implement policies and procedures in accordance with this policy.

AdSS Behavioral Health Providers must coordinate member care with Division of Developmental Disabilities (Division) by performing all of the following:

A. Inviting Division staff (e.g., Support Coordinator) to participate in the development of the behavioral health service plan and all subsequent planning meetings as representatives of the member’s clinical team (see Division Medical Policy 320-O)

B. Incorporating information and recommendations in the Planning Document (e.g., Individual or Family Support Plan (ISP)) developed by the Planning Team, when appropriate

C. Ensuring that the goals of the Planning Document, of a member diagnosed with developmental disabilities who is receiving psychotropic medications, includes reducing behavioral health symptoms and achieving optimal functioning, not merely the management and control of challenging behavior

D. Actively participating in Division team meetings

E. For members diagnosed with Autism Spectrum Disorder and Developmental Disabilities, sharing all relevant information from the initial assessment and Planning Document with Division to ensure coordination of services.

For Division members with a co-occurring behavioral health condition or physical health condition who demonstrate inappropriate sexual behaviors and/or aggressive behaviors, a Community Collaborative Care Team (CCCT) may be developed. For additional information regarding the roles and responsibilities of the CCCT and coordination of care expectations, see Division Medical Policy 570.

The AdSS must develop and make available to providers policies and procedures that include information on Division-specific protocols or agreements.

**Courts and Corrections**

The AdSS must collaborate and coordinate care and ensure that behavioral health providers collaborate and coordinate care for members with behavioral health needs and for members involved with:
A. Arizona Department of Corrections (ADOC)
B. Arizona Department of Juvenile Corrections (ADJC)
C. Administrative Offices of the Court (AOC).

The AdSS must collaborate with courts and/or correctional agencies to coordinate member care by performing all of the following:

A. Working in collaboration with the appropriate staff involved with the member,
B. Inviting probation or parole representatives to participate in the development of the ISP and all subsequent planning meetings for the Adult Recovery Team (ART) with the member’s approval,
C. Actively considering information and recommendations contained in probation or parole case plans when developing required plans
D. Ensuring that the behavioral health provider evaluates and participates in transition planning prior to the release of eligible members and arranges and coordinates enrolled member care upon the member’s release (see Division Medical Policy 580).

**Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA)**

The AdSS must coordinate member care (in collaboration with the assigned Support Coordinator) with ADES/RSA by:

A. Working in collaboration with the vocational rehabilitation counselors or employment specialists in the development and monitoring of the member’s employment goals
B. Ensuring that all related vocational activities are documented in the comprehensive clinical record (see Division Medical Policy 940)
C. Inviting ADES/RSA staff to be involved in planning for employment programming to ensure that there is coordination and consistency with the delivery of vocational services
D. Participating and cooperating with ADES/RSA in the development and implementation of a Regional Vocational Service Plan inclusive of ADES/RSA services available to adolescents
E. Allocating space and other resources for vocational rehabilitation counselors or employment specialists working with enrolled members who have been determined to have a Serious Mental Illness.
1060 TRAINING REQUIREMENTS FOR BEHAVIORAL HEALTH PROVIDERS

EFFECTIVE DATE: October 1, 2019

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). To meet the requirements of the Division and Arizona Health Care Cost Containment System (AHCCCS), the AdSS must participate in the development, implementation and support of trainings for behavioral health contractors and subcontractors to ensure appropriate training, education, technical assistance, and workforce development opportunities. AdSS are required specifically to:

A. Promote a consistent practice philosophy, provide voice and empowerment to staff and members.
B. Ensure a qualified, knowledgeable and culturally competent workforce.
C. Provide timely information regarding initiatives and best practices.
D. Ensure that services are delivered in a manner that results in achievement of the Arizona System Principles, which include the Adult Service Delivery System - Nine Guiding Principles as outlined in Contract and Arizona Vision - Twelve Principles for Children Service Delivery as outlined in Division Medical Policy Manual, Policy 430.

The purpose of this policy is to provide information to behavioral health providers regarding:

- The scope of required training topics
- How training needs are identified for behavioral health providers
- How behavioral health providers may request specific technical assistance from the AdSS.
- Trainings required to be provided by behavioral health providers.

**Required Training for Behavioral Health Providers**

A. The AdSS must monitor and implement training activities and requirements outlined in this policy. The AdSS must annually evaluate the impact of the training requirements and activities in order to develop a qualified, knowledgeable and culturally competent workforce.

1. The AdSS and its providers must ensure that, before providing services to members, each licensed and unlicensed staff person is qualified, knowledgeable, and capable to provide services as required by Division policy and, as relevant to their job duties and responsibilities, consistent with the approved training content specified in this policy under Sections One, Section Two, and Section Three (below).

2. Licensed and unlicensed personnel attend and complete all pre-service,
ongoing and or annual in-service training programs described and required by specific Division policies:

3. Section One
   a. Fraud and program abuse recognition and reporting requirements and protocols
   b. Managed care concepts, including information on the behavioral health provider, and the public behavioral health system
   c. Screening for eligibility, enrollment for covered behavioral health services (when eligible), and referral when indicated
   d. Overview of Arizona behavioral health system policies and procedures in the Arizona Vision and 12 Principles (AMPM Policy 430) in the children’s system
   e. Overview of Arizona's behavioral health system policies and procedures in the 9 Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems Adult Service Delivery System-Nine Guiding Principles
   f. Overview of Developmental Disabilities, including partnership with Department of Economic Security/Division of Developmental Disabilities and training specific to the needs of individuals with Developmental Disabilities
   g. Overview of partnership with Department of Economic Services/Rehabilitative Services Administration (DES/RSA)
   h. Cultural competency; including cultural diversity in persons with Developmental Disabilities
   i. Interpretation and translation services
   j. AHCCCS Demographic Data Set, including required timeframes for data submission and valid values
   k. Identification and reporting of quality of care concerns and the quality of care concerns investigation process

4. Section Two
   a. Use of assessment and other screening tools (e.g., substance-related, crisis/risk, developmental, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program), including the Birth-to-Five Assessment adopted by the Division on the AHCCCS website depending upon population(s) served
   b. Use of effective interview and observational techniques that support
engagement and are strengths-based, recovery-oriented, and culturally sensitive

c. Application of diagnostic classification systems and methods depending upon population(s) served

d. Best practices in the treatment and prevention of behavioral health disorders

e. Behavioral health service planning and implementation which includes family vision and voice, developed in collaborations with the individual/family needs as identified through initial and ongoing assessment practices

f. Covered behavioral health services (including information on how to assist persons in accessing all medically necessary covered behavioral health services regardless of a person's behavioral health category assignment or involvement with any one type of service provider)

g. Overview of Substance Abuse Block Grant (SABG): priority placement criteria, interim service provision, consumer wait list reporting, and expenditure restrictions of the SABG in accordance with requirements in Division Operations Policy Manual 417, Division Medical Policy Manual 320-T, and 45 CFR Part 96

h. AHCCCS National Practice Guidelines and Clinical Guidance Documents with required elements

Behavioral health providers must receive training on the AHCCCS National Practice Guidelines and Clinical Guidance Documents with required elements before providing services, but must receive training within six months of the staff person's hire date (protocol training is only required if pertinent to populations served).

i. Clinical training as it relates to specialty populations including but limited to conditions based on identified need

j. Information regarding the appropriate clinical approaches when delivering services to individuals with developmental disabilities

k. Information regarding the appropriate clinical approaches when delivering services to children in the care and custody of the Arizona Department of Child Safety (DCS)

l. Understanding behavioral and environmental risk factors, nonphysical interventions, the safe use of seclusion or restraint, and responding to emergency situations in accordance with this Policy Manual Chapter 960, Tracking and Trending of Member and Provider Issues

5. Section Three
a. Behavioral health record documentation requirements (see this Policy Manual Chapter 940)
b. Confidentiality/Health Information Portability and Accountability Act (HIPAA)
c. Sharing of treatment/medical information
d. Coordination of service delivery for persons with complex needs (e.g., persons at risk of harm to self and others, court ordered to receive treatment)
e. Rights and responsibilities of eligible and enrolled members, including rights for persons determined to have Serious Mental Illness (SMI)
f. Grievance and Appeal System including SMI grievances, and requests for investigations
g. Customer service
h. Coordination of care requirements with Primary Care Providers (PCPs) (see this Policy Manual Chapter 500)
i. Third party liability and coordination of benefits (see the Division’s Operations Policy Manual and 201)
j. Other involved agencies and government entities (see this Policy Manual Chapter 1050)
k. Claims/encounters submission process (see the Division’s Operations Policy Manual 203)
l. Advance Directives (see this Policy Manual Chapter 640)
m. Identification and reporting of persons in need of Special Assistance for individuals who have been determined to have a SMI and ensuring involvement of persons providing Special Assistance (see this Policy Manual Chapter 320-R)

n. Providers delivering services through distinct programs (e.g., Assertive Community Treatment teams, Dialectical Behavioral Therapy, Multi-Systemic Therapy, developmental disabilities, trauma, substance abuse, children age birth to five, and Behavioral Health Inpatient Facilities)
o. Member benefit options trainings: such as Medicare Modernization Act (MMA), DES/RSA and SABG.

B. Specific situations may require additional trainings. For example, quality improvement initiatives that may require focused training efforts and/or new regulations that affect the public behavioral health system (e.g., the Balanced
Budget Act (BBA), MMA, the Affordable Care Act (ACA) and Deficit Reduction Act (DRA). Additional trainings may be required, as determined by geographic service area identified needs.

C. The AdSS must develop and make available to providers any policies and procedures regarding additional training information.

Annual and Ongoing Training Requirements

A. In addition to training required within the first 90 days of hire, all Behavioral Health providers are required to undergo and provide ongoing training for the following content areas:

1. AHCCCS Demographic Data Set, including required timeframes for data submission, valid values and as changes occur
2. Trainings concerning procedures for submissions of encounters as determined by AHCCCS
3. Annual cultural competency and linguistically appropriate training updates for staff at all levels and across all disciplines respective to underrepresented/underserved populations
4. Identification and reporting of Quality of Care Concerns and the Quality of Care Concerns investigations process when determined to be needed by the Division
5. American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC-2R)
6. Child and Adolescent Service Intensity Instrument (CASII)
7. Ticket to Work/Disability Benefits 101
8. Peer, family member, peer-run, family-run and parent-support training and coaching
9. Identification and reporting of persons in need of Special Assistance for individuals who have been determined to have a SMI and ensuring involvement of persons providing Special Assistance (see this Policy Manual Chapter 320-R)
10. Workforce Development trainings specific to hiring, support, continuing education and professional development.

B. Specific situations may require additional trainings. For example, quality improvement initiatives that may require focused training efforts and/or new regulations that impact the public behavioral health system (e.g., the BBA, MMA, ACA, and DRA). Additional trainings may be required, as determined by geographic service area identified needs.
C. The AdSS must develop and make available to providers any policies and procedures regarding specific ongoing training requirements. ADHS Public Health Licensing required training must be completed and documented in accordance with Public Health Licensing requirements (see applicable provisions of A.A.C. Title 9, Chapter 10. and the ADHS Public Health Licensing website).

**Required Training Specific to Professional Foster Homes Providing HCTC Services**

A. Children

Medicaid reimbursable HCTC services for children are provided in professional foster homes, licensed by the DES/Office of Licensing, Certification and Regulation, which must comply with training requirements as listed in A.A.C. R6-5-5850. All agencies that recruit and license professional foster home providers must provide and credibly document the following training to each contracted provider:

1. CPR and First Aid Training and
2. 18 hours of pre-service training using the HCTC to Client Service Curriculum.

The provider delivering HCTC services must complete the above training before delivering services. In addition, the provider delivering HCTC services for children must complete and credibly document annual training as outlined in A.A.C. R6-5-5850, Special Provisions for a Professional Foster Home.

B. Adults

Medicaid reimbursable HCTC services for adults are provided in Adult Therapeutic Foster Homes licensed by ADHS Public Health Licensing, and must comply with training requirements as listed in applicable sections of A.A.C. Title 9, Chapter 10. Training must cover:

1. Protecting the person's rights
2. Providing behavioral health services that the adult therapeutic foster home is authorized to provide and the provider delivering HCTC services is qualified to provide
3. Protecting and maintaining the confidentiality of clinical records
4. Recognizing and respecting cultural differences
5. Recognizing, preventing or responding to any of the following situations in which a person:
   a. May be a danger to self or a danger to others
   b. Behaves in an aggressive or destructive manner
   c. May be experiencing a crisis
d. May be experiencing a medical emergency.

6. Reading and implementing a person’s treatment plan, and

7. Recognizing and responding to a fire, disaster, hazard or medical emergency.

In addition, providers delivering HCTC services to adults must complete and credibly document annual training as required by A.A.C. Title 9, Chapter 10.

**Required Training Specific to Community Service Agencies**

Community Service Agencies (CSAs) must submit documentation as part of the initial and annual CSA application indicating that all direct service staff and volunteers have completed training specific to CSAs before providing services to members. For a complete description of all required training specific to CSAs, see AMPM 961, *Peer, Family and CSA Training, Credentialing and Oversight Requirements*.

**Training Expectations for AHCCCS Clinical and Recovery Practice Protocols**

A. Under the direction of the Division’s Chief Medical Officer and the AHCCCS Chief Medical Officer national practice guidelines and clinical guidance documents are published to assist behavioral health providers.

B. Behavioral health providers providing services to children and families involved with DCS will be required to attend "Unique Needs of Children Involved with DCS" training that must be offered by each AdSS Behavioral Health Providers on a regular basis (See AHCCCS Practice Protocol, The Unique Behavioral Health Service Needs of Children, Youth and Families Involved with DCS).

C. Training on Child and Family Team (CFT) practice, depending on the population(s) served (See AHCCCS Practice Protocol Child and Family Team).

D. Training curriculums may be tailored to specific professional levels (e.g., BHMP, BHT, BHPP) and or job functions (e.g., Coach, Family Support Partner, Supervisor) so long as curriculums are consistent with the CFT Practice Protocol. Curriculums and certification processes must be submitted for approval to the Division.

**Training Requests**

The AdSS must make available to providers any policies, procedures, and contact information that identify how providers can access additional training and/or technical assistance specific to the trainings required by this policy and/or other types of applicable training resources.

**Workforce Development**

A. The AdSS must develop and make available to providers any additional policies and procedures regarding specific workforce development requirements.

B. Training Expert – The AdSS must employ a training expert/contact as key personnel and point of contact to implement and oversee compliance with the
training requirements, training plan, and this policy.

C. Training Development Plan - The AdSS must develop, implement and submit an Annual Training Plan that provides information and documentation of all trainings. The training plan and training curriculums will be submitted annually, 45 days after fiscal year end as specified in Section F3, Contractor Chart of Deliverables.

D. Training Quarterly Updates - The AdSS must submit a Workforce Development Quarterly Update which includes information specific to initiatives and activities specific to training. Quarterly updates are to be submitted 30 days after quarter end as specified in Section F3, Contractor Chart of Deliverables.

**Provision of Training Related to Behavior Health Plans**

The AdSS must ensure that any Behavioral Health entity/provider, that develops a Behavior Plan for a member, trains family members and all staff to implement the plan with fidelity.
1210 INSTITUTIONAL SERVICES AND SETTINGS

EFFECTIVE DATE: October 1, 2019

This policy applies to AdSS and its contractors. The Division of Developmental Disabilities (Division) covers medically necessary institutional services provided in an Arizona Health Care Cost Containment System (AHCCCS) registered long term care facility for members who are eligible for the Arizona Long Term Care System (ALTCS). Institutional settings include Behavioral Health Inpatient facilities, Institutions for Mental Disease (IMD), Inpatient Behavioral Health Residential Treatment Facilities and Nursing Facility (NF) Services.

AdSS Contractors are responsible for ensuring that providers delivering institutional services to members must meet the requirements as specified in this Manual. For purposes of this Service Specification, the term “Contractor” refers to the facility.

Prior to a denial of NF services, the AdSS must contact the Division for a second level review.

Nursing Facility

See Chapter 310-R of this manual regarding acute NF Services for members who are ALTCS eligible and members in the ALTCS transitional program.

Service Description and Goals

This service provides habilitative skilled nursing care, residential care, and supervision to persons who need nursing services on a 24-hour basis, but who do not require hospital care or direct daily care from a physician.

The goal of this service is to provide care that meets and enhances the medical, physical, and emotional needs of members residing in Nursing Facilities (NF).

Service Settings

NFs must be Medicare and Medicaid certified and licensed by the Arizona Department of Health Services in accordance with 42 CFR 440.155 and 42 CFR 483.75 to provide inpatient room, board, and nursing services to members who require these services on a continuous basis. For the purposes of reimbursement by ALTCS funding, the facility must be Medicare/Medicaid certified.

Contractor Requirements

The Contractor must:

A. Be licensed and certified by the appropriate Arizona state agencies.

B. Comply with all applicable federal and state laws relating to professional conditions, standards, and NF requirements, including the conditions set forth in the 42 CFR 483 et seq.
C. Comply with all health, safety, and physical plant requirements established by federal and state laws.

D. The portion of the facility in which the member will be placed must be registered with AHCCCS.

E. Provide all services in a culturally relevant and linguistically appropriate manner for the population to be served.

F. Provide services to members who meet the eligibility requirements for such services as determined by the AdSS and who have been evaluated and placed by the AdSS in coordination with the Division.

G. Provide a healthy, safe, and clean environment that meets the medical, physical, and emotional needs of the member.

H. Provide services, equipment, and supplies as specified in A.A.C. R9-28-204(B), as may be amended.

I. Responsible for coordinating the delivery of the auxiliary services specified in A.A.C. R9-28-204(C), as may be amended.

J. Maintain a complete file for each member that includes physician’s orders, care plans, treatment records, medication records, evaluations and assessments, progress reports and any other needed documentation. The member’s file must be made available to the AdSS immediately, or as specified by the Division.

K. Ensure that a PASRR Level I assessment is completed on members prior to admission and whenever a significant change in the physical or mental status of the member occurs.

1. Failure to have the proper PASRR screening on file, prior to placement of a member in a Skilled Nursing Facility may result in federal financial participation (FFP) withheld from AHCCCS. If withholding of FFP occurs, the Division will recoup the withheld amount from the AdSS’s subsequent capitation payment. The AdSS may, at its option, recoup the withholding from the Contractor that admitted the member without the proper PASRR.

2. Ensure that the completed PASRR Level I is maintained in the member’s file, and appropriate referrals made, as needed.

3. If there are indications that a member may have a cognitive/intellectual disability or a related diagnosis, forward the completed PASRR Level I and all supporting documentation, including Minimum Data Set (MDS), health and progress notes, assessments, or other supporting documentation to the AdSS, who is responsible to forward the submitted documents to the Division’s Health Care Services Representative (i.e., the PASRR Coordinator). The Division is responsible for completing PASRR Level II reviews.

L. PASRR Level II reviews must occur for each member whose expected stay in the Skilled Nursing Facility will exceed 90 days.
1. If the results of a PASRR Level II review indicate there is a change in the member’s condition, ensure:
   a. Recommendations are followed,
   b. Appropriate referrals are made, as needed, and
   c. The Division’s Health Care Services representative (e.g., the PASRR Coordinator) is contacted for prior approval before billing a different level of care.
   d. Ensure that any subsequent documentation (e.g., PASRR Level II) is maintained in the member’s file.

M. Complete a quarterly review of the member to assess key indicators or resident status and revise the plan of care as necessary.

N. Conduct a reassessment within one year or whenever there is a significant change in the member’s status.

O. Provide medical, physical, and emotional care and supervision as follows:
   1. Provide nursing care treatment as indicated in the prescribed care plan. The care plan must be specific to the member and be available immediately or as specified by the AdSS.
   2. Provide dietary management, including the preparation and administration of special diets and adaptive mealtime equipment.
   3. Provide access to dental care and treatment, in accordance with Chapter 300 of the Division’s Medical Policy Manual.
   4. Provide access to podiatric care and treatment, in accordance with Chapter 300 of the Division’s Medical Policy Manual.
   5. Provide activities (e.g., therapeutic, vocational), recreational services, and spiritual services in accordance with the member’s preference.
   6. Provide coordination of services to the member from various agencies, as appropriate. Maintain records of interactions with other agencies or service providers relative to the member.
   7. Participate in the development and review of the member’s planning document (e.g., Individual Support Plan, Individualized Family Services Plan).
   8. Participate in discharge planning following the process specified in the Division’s Policy Manuals, as may be amended.
   9. Provide an outcome measurement system whereby the member/member’s representative can provide feedback regarding satisfaction with the performance of the Contractor. The outcome measurement system must be made available to the AdSS upon request.
P. Provide Progress Reports on the member’s planning document (e.g., ISP) objectives every thirty (30) days to the designated Support Coordinator

**Contractor Qualifications**

A. Skilled Nursing Facility(s) must be licensed by the Arizona Department of Health Services (ADHS) and Medicare/Medicaid certified in accordance with 42 C.F.R. § 483, as may be amended.

B. Skilled Nursing Facility(s) must be is licensed, certified, and monitored in accordance with A.R.S. Title 6, Chapter 4, as may be amended.

C. Skilled Nursing Facility(s) must be registered with AHCCCS to provide this service for that portion of the facility subject to Title XIX (Medicaid) reimbursement.

D. Comply with all applicable federal and state laws relating to professional conditions, standards and requirements for nursing facilities, and all health, safety and physical plant requirements established by federal and state laws.

E. Have procedures that ensure temporary nursing care registry personnel, including Nurses’ Aides, are properly certified and licensed before caring for members, in accordance with 42 C.F.R. § 483.75(e)3 and (g)2 and fingerprinted as required by A.R.S. § 36-411, as may be amended.

F. Maintain on-site files that document appropriate licenses and inspections. Files must be made available to the AdSS immediately upon request or as specified by the AdSS.

**Admission Criteria (Nursing Facility)**

A. The NF service may be considered appropriate for a member if the member is in need of skilled nursing care on a 24-hour basis but does not require hospital care or direct daily care from a physician and is ordered by, and provided under, the direction of a physician, pursuant to 42 CFR 440.40 and a less restrictive level of care is not available in a home and community case service setting as determined by the member’s planning team.

B. The AdSS must contact the Division by Day 45 of a member’s acute NF placement to discuss long term placement alternatives and coordinate discharge planning with the Division. Prior to consideration of long term NF placement as outlined in this chapter, the AdSS must obtain approval from the Division. The Division will use an acuity tool will determine the level of institutional placement prior to placement. If the Primary Care Provider (PCP) or the Division advises that the NF cannot meet the member’s needs, the member shall be offered a choice of available alternatives, including less restrictive settings and/or Home and Community Based Services (HCBS), as medically necessary.

C. Pursuant to 42 CFR 409.31-35 and 440.155, the member requires:

1. The skills of technical or professional personnel such as registered nurses, licensed practical nurses, or therapists
2. Daily skilled services that can only be provided in an NF, on an inpatient basis

3. Skilled services because of special medical complications

4. Services that are above the level of room and board.

Reassessment for Continued Placement

A. Members residing in an NF must be reassessed by the AdSS for appropriateness (medical necessity) of placement, whenever a significant change in the physical or mental status of the member occurs (see PASARR section of this policy manual).

B. Physicians must order the continued need for NF placement not less than annually in accordance with 42 CFR 483.114.

C. The member must continue to meet the criteria in the Admission Criteria (Nursing Facility) section of this Policy.

Service Closure (Nursing Facility)

As determined by the PASRR, medical documentation, and the current needs of the member, NF services will be terminated by the AdSS when the criteria in the Admission Criteria (Nursing Facility) section of this Policy are no longer met and alternative placement has been identified. The discharge shall occur as follows:

A. Ten days prior to anticipated discharge, a Planning Team Meeting must occur to allow the support coordinator to update the current Planning Document to include:

1. The member’s health and abilities

2. Current medication

3. Identification of needed Durable Medical Equipment (DME)

4. An updated Service Plan

5. A completed Cost Effectiveness Study (CES) based on anticipated service needs

6. Needed follow up medical appointments.

B. The Planning Team includes the member and/or responsible person, the Division’s Health Care Service (HCS) nurse, the Support Coordinator, and representatives from the NF. The Planning Team may also include other representatives as needed per Division’s Operations Manual, Policy 2001 Planning Team Members.

C. In the event the member’s previous living arrangement needs to change, the Support Coordinator makes a request for residential services by completing a Placement Profile and submitting it to the Division’s District Network Unit.

D. The member or responsible person, the PCP, attending Physician, and the Division’s Medical Director shall resolve disagreements regarding discharge planning.
E. The Division’s Chief Medical Officer has the final authority as delegated by the Assistant Director.

**NF Contract Termination**

If the AdSS places an NF on termination status:

A. No new members will be admitted to the NF.

B. Members currently residing, or on leave from, the NF may remain or return to the facility and will have a special planning meeting scheduled. The planning meeting must include the Division’s support coordinator and must identify contracted residential alternatives that are available to the member.

**Behavioral Health**

Institutional settings also include Behavioral Health Inpatient facilities, Institutions for Mental Disease (IMD), and Inpatient Behavioral Health Residential Treatment Facilities.

**Behavioral Health Inpatient Facility**

A Behavioral Health Inpatient Facility is a behavioral health service facility licensed by ADHS, as defined in A.A.C. R9-10-101, to provide a structured treatment setting with 24-hour supervision, on-site medical services, and an intensive behavioral health treatment program. These facilities are the highest level of inpatient behavioral health services. Some Behavioral Health Inpatient Facilities are IMDs.

**Institution for Mental Disease (IMD)**

Services provided to members eligible for Title XIX (including members who receive behavioral health services through an Integrated/Tribal/Regional Behavioral Health Authority (IRBHA, RBHA, TRBHA) may be reimbursed in any behavioral health setting, regardless of age, as per AHCCCS Medical Policy Manual, Policy 1210.

An IMD is a Medicare-certified hospital, special hospital for psychiatric care, behavioral health facility, or nursing care institution which has more than 16 treatment beds and provides diagnosis, care, and specialized treatment services for mental illness or substance abuse for more than 50% of the members is considered an IMD. ADHS Office of Behavioral Health Licensure-licensed Inpatient facilities with more than 16 beds are considered IMDs.

**Inpatient Psychiatric Residential Treatment Center (available to Title XIX members under 21 years of age)**

An Inpatient Psychiatric Residential Treatment Center is a behavioral health service facility licensed by ADHS. Services must be provided under the direction of a physician and include active treatment implemented as a result of the service plan developed. The service plan must include an integrated program of therapies, activities, and experiences designed to meet the treatment objectives for the member. A member who turns age 21 and is Tribal ALTCS Title XIX while receiving services in an inpatient psychiatric facility considered to be an IMD may continue to receive services until the point in time in which services are no longer required or the member turns age 22, whichever comes first.
In addition, the following services must be available to members residing in a behavioral health institutional setting, but are not included in the service unit:

A. Speech, physical, and occupational therapies unless required as a part of the per diem for the service unit

B. Medical/acute care services as specified in this Policy Manual.
1240-D  EMERGENCY ALERT SYSTEM

EFFECTIVE DATE: October 1, 2019

Description
An Emergency Alert System is a monitoring device/system for members who are unable to access assistance in an emergency situation.

Emergency Alert System may include:
A. A one emergency alert system unless a second is medically necessary
B. Medically necessary accessories for operation
C. Replacement of equipment in cases of loss, irreparable damage, or wear not caused by carelessness or abuse.

Considerations
The following factors will be considered when assessing the need for this service:
A. The member lives alone or is alone for eight or more hours without contact with a service provider, family member, or other support system and cannot call 911 by using a standard phone, portable phone, or cell phone.
B. The member’s community does not have reliable/available emergency assistance on a 24-hour basis.
C. The assessment of the member’s medical and/or functional level documents an acute or chronic medical condition, which is not improving.
D. The primary care provider has prescribed the system.

Settings
An Emergency Alert System may only be provided in the member’s own or family home.

Exclusions
An Emergency Alert System will not be provided:
A. To members living in Group Homes or Child/Adult Developmental Homes
B. When the member no longer meets the target population/service considerations (e.g., the member moves to a Group Home or the member is no longer alone for eight hours or more). When this occurs, the system and all components must be returned to the Division.
1250-E THERAPIES (REHABILITATIVE/HABILITATIVE)

EFFECTIVE DATE: October 1, 2019
REFERENCES: AHCCCS AMPM 310-X, Attachment A

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The Division covers occupational, physical, respiratory and speech therapy services that are ordered by a Primary Care Provider (PCP), approved by the Division or AdSS, and provided by or under the direct supervision of a licensed therapist as noted and applicable in this policy. The AdSS is responsible for providing rehabilitative therapy and habilitative physical therapy services for members Age 21 and older.

Members residing in their own home, and HCB approved alternative residential setting or an institutional setting may receive physical, occupational and speech therapies through a licensed Medicare-certified Home Health Agency (HHA) or by a qualified licensed physical, occupational, or speech therapist in independent practice, as applicable.

Services require a PCP or attending physician’s order and must be included in the member’s record. The record must be reviewed at least every 62 days (bi-monthly) by the member’s PCP or attending physician.

Therapy services must be prescribed by the member’s PCP or attending physician as a medically necessary treatment to develop, improve or restore functions/skills which have not been attained, are underdeveloped or have been impaired, reduced or permanently lost due to illness or injury. Therapy services related to activities for the general good and welfare of members, activities to provide diversion or general motivation do not constitute therapy services for Medicaid purposes and are not covered.

The therapy must relate directly and specifically to an active written treatment regimen or care plan established by the member’s physician for reasonable and necessary treatment of a member’s illness or injury, habilitation or rehabilitation. If necessary, the physician should consult with a qualified therapist.

For purposes of the Policy, reasonable and necessary means:

A. The services must be considered under accepted standards of medical practice to be specific and effective treatment for the member’s condition.

B. Based on the amount, frequency, and duration of the services must be reasonable.

Developmental/Restorative Therapy

A therapy service must be reasonable and necessary to the functional development, and/or treatment of the member’s illness or injury. If the member’s expected potential for improving or restoring functional level is insignificant in relationship to the type and number of therapy services required to achieve such potential the therapy would not be covered for other than a maintenance program as described below. If at any point in the development of skills, or the treatment of an illness or injury, it is determined that the therapy expectations will not materialize, the services will no longer be considered reasonable and necessary.
**Maintenance Program**

If the developmental or restorative potential is evaluated as insignificant or at a plateau, an appropriate functional maintenance program may be established. The specialized knowledge and judgment of a qualified therapist may be required to assess and establish the maintenance program to achieve the treatment goals of the ordering PCP or attending physician. After the member’s condition has been assessed, and the member’s caregiver has been instructed/trained in the established maintenance program components, the services of the qualified therapist are no longer covered except for reassessments and treatment plan revisions. Refer to Division Medical Manual Chapter 300 for additional information regarding therapy services.

**Habilitative Therapy**

Habilitative therapy directs the member’s participation in selected activities to facilitate and/or improve functional skills. Additionally, habilitative therapy is described in terms of everyday routines and activities related to achieving the goals/outcomes described in the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) and is based on needs identified in these respective documents. Habilitative therapy is available through the Division and some Health Plans through Early and Periodic Screening, Diagnosis, and Treatment Medicaid program. Habilitative therapy also provides for direct treatment by a licensed therapist.

Habilitative therapy may use direct treatment by a licensed therapist and is time limited and outcome driven. All therapy is consultative in nature.

**Occupational, Physical and Speech Therapy**

**Therapy Descriptions (Occupational, Physical and Speech)**

A. **Physical Therapy**

   The Division covers inpatient and outpatient Physical Therapy (PT) services to members eligible for the Division and ALTCS. Services provide treatment to develop, restore, maintain or improve muscle tone and joint mobility and to develop or improve the physical/functional capabilities of members. Physical therapy may address the movement of the body related to walking, standing, balance, transferring, reaching, sitting, and other movements.

B. **Occupational Therapy**

   The Division covers inpatient and outpatient occupational therapy for members eligible for the Division and ALTCS to achieve their highest level of functioning, maximize independence, prevent disability and maintain health. Occupational therapy may address the use of the body for daily activities such as, dressing, sensory and oral motor development, movement, and eating.

   Services may be provided to members who are functionally limited due to physical injury or illness, psychosocial dysfunction, developmental or learning disabilities, or the aging process.
C. **Speech Therapy**

The Division covers inpatient and outpatient speech therapy services including evaluation, program recommendation for treatment and/or training in receptive and expressive language, voice, articulation, fluency and aural habilitation and rehabilitation, and medical issues dealing with swallowing.

Barring exclusions noted in this section, Therapy includes the following:

A. **Evaluation of skills**

B. **Development of home programs and consultative oversight with the member, family and other providers**

C. **Assisting members to acquire knowledge and skills, increase or maintain independence, promote health and safety**

D. **Modeling/teaching/coaching parents and/or caregivers specific techniques and approaches to everyday activities, within a member’s routine, in meeting their priorities and outcomes**

E. **Collaboration with all team members/professionals involved in the member’s life.**

**Responsible Person’s Participation (Occupational, Physical and Speech)**

To maximize the benefit of this service, improve outcomes and adhere to legal liability standards, parents/family or other caregivers (paid/unpaid) are required to:

A. **Be present and actively participate in all therapy sessions.**

B. **Carry out the home program.**

**Considerations (Occupational, Physical and Speech)**

The following will be considered when approving this service:

A. **Developmental/functional skills**

B. **Medical conditions**

C. **Member’s network of support (e.g., family/caregivers, friends, providers)**

D. **Age**

E. **Therapies provided by the school.**
Settings (Occupational, Physical and Speech)

Therapy must be provided in settings that support outcomes developed by the team. This includes:

A. The member’s home
B. Community settings
C. Division funded settings such as day programs and residential settings for the purpose of training staff
D. Daycare
E. A clinic/office setting.

Exclusions (Occupational, Physical and Speech)

Exclusions to the authorization of Therapy services may include, but are not limited to, the following:

A. Limits as specified in AHCCCS AMPM 310-X, Attachment A – AHCCCS Adult Member (Persons Age 21 and Older) Therapy Benefit Table
B. Therapy for educational purposes.

Respiratory Therapy

The Division covers respiratory care services prescribed by a PCP or attending physician to restore, maintain or improve respiratory functioning. Services include administration of pharmacological, diagnostic and therapeutic agents related to respiratory and inhalation care procedures; observing and monitoring signs and symptoms, general behavioral and general physical response to respiratory care; diagnostic testing and treatment; and implementing appropriate reporting and referral protocols.

Service Description and Goals (Respiratory Therapy)

This service provides treatment to restore, maintain or improve respiration.

The goals of this service are to:

A. Provide treatment to restore, maintain or improve respiratory functions.
B. Improve the functional capabilities and physical well-being of the member.

Service Settings (Respiratory Therapy)

The Division does not authorize rates for respiratory therapy as a stand-alone service that is separate from other services provided in a particular setting. Although, respiratory therapy may be provided to the member in any setting, it is part of the established rate for Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID) and Nursing Facilities (NF).
Service Requirements (Respiratory Therapy)

Before Respiratory Therapy can be authorized, the following requirements must be met:

A. The service must be prescribed by a qualified, licensed physician as part of a written plan of care that must include the frequency, duration, and scope of the therapy.

B. The provider must be licensed by the Arizona Board of Respiratory Care Examiners and be a graduate of an accredited respiratory care education program. This program must be accredited/approved by the American Medical Association’s Committee on Allied Health Education and in collaboration with the Joint Review Committee for Respiratory Therapy Education.

C. The provider must be designated for members who are eligible for ALTCS services and registered with the AHCCCS.

D. Tasks may include:
   1. Conducting an assessment and/or review previous assessments, including the need for special equipment
   2. Developing treatment plans after discussing assessments with the Primary Care Provider, Nurse and the Planning Team
   3. Implementing respiratory therapy treatment as indicated by the assessment(s) and the member’s treatment plan
   4. Monitoring and reassessing the member’s needs on a regular basis
   5. Providing written reports to the AdSS staff, as requested
   6. Attending Planning Meetings (Individual Support Plan/Individualized Family Services Plan/Person Centered Plan meetings) if requested by the member and Division staff
   7. Developing and teaching therapy objectives and/or techniques to be implemented by the member, caregivers and/or other appropriate individuals
   8. Consulting with members, families, Support Coordinators, medical supply representatives, and other professional, and paraprofessional staff on the features and design of special equipment
   9. Giving instruction on the use and care of special equipment to the member and care providers.

Target Population (Respiratory Therapy)

This service is indicated for members who have a health condition that require respiratory therapy, as ordered by a physician, which is documented in the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents).
Exclusions (Respiratory Therapy)

Respiratory Therapy is prohibited without Physicians orders and prescriptions for certain medical procedures. This requirement does not apply to private or state-operated Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID).

Service Provision Guidelines (Respiratory Therapy)

Respiratory Therapy must not exceed eight (8) fifteen (15) minute sessions per day.

Provider Types and Requirements (Respiratory Therapy)

Designated District staff will ensure all contractual requirements related to Respiratory Therapy providers are met before the service is approved. Additionally, all providers of ALTCS must be registered with the AHCCCS prior to service initiation.

Service Evaluation (Respiratory Therapy)

A. The Primary Care Provider (PCP) must review the plan of care at least every 60 days and prescribe continuation of service.

B. If provided through a Medicare certified home health agency, the supervisor must review the plan of care at least every 60 days.

C. The provider must submit progress notes on the plan of care on a monthly basis to the Division Support Coordinator.

Service Closure (Respiratory Therapy)

Service closure should occur in any of the following situations:

A. The physician determines that the service is no longer needed as documented on the “Plan of Care.”

B. The member/responsible person declines the service.

C. The member moves out of state.

D. The member requires other services, such as home nursing.

E. The member/responsible person has adequate resources or other support to provide the service.

The Division supports and encourages continuity of care among all therapy resources such as hospitals, outpatient rehabilitation clinics, and schools. The Division contracted therapists must collaborate with other service providers and agencies involved with the member.
1250-F  CUSTOMIZED DURABLE MEDICAL EQUIPMENT, AND APPLIANCES

EFFECTIVE DATE: October 1, 2019

Adaptive Aids (Acute Care Services)

Certain medically necessary adaptive aids qualify as a covered service if prescribed by a specialist physician, practitioner, or dentist upon referral by a Primary Care Provider (PCP).

Documentation from therapists who have treated the member may be required. That documentation must establish the need for equipment and a comprehensive explanation of how the member will benefit from the equipment. It is important to remember that this service is based on “assessed need” and not a person’s or the family’s stated desires regarding specific services.

Covered adaptive aids are limited to:

A. Traction equipment
B. Feeding aids (including trays for wheelchairs)
C. Helmets
D. Standers, prone, and upright
E. Toileting aids
F. Wedges (positioning)
G. Transfer aids
H. Augmentative communication devices
I. Medically necessary car seats
J. Other items as determined medically necessary by joint consultation of the Medical Directors of the health plan and the Division.