

AHCCCS POLICY UPDATES

October 27, 2009

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Dear Care1st Practitioners and Office Staff:

Earlier this year, AHCCCS, in conjunction with its contracted health plans, reviewed the Medicaid benefit package to address the significant fiscal challenges and growth in the Medicaid population in Arizona. The Benefit Redesign proposal was open for public comment (both in writing and public hearing) in June 2009. All comments were reviewed very carefully. As a result of the feedback and of the FY 2010 reductions, AHCCCS, in collaboration with its contracted health plan Medical Directors, implemented several changes effective October 1, 2009. These changes did not require legislative approval.

The sections of policy that were modified are described below. Detailed information regarding the policy updates along with the updated policy manual can be found by following the link below to the AHCCCS website and clicking the What's New October – First Update link or the link to Chapter 300 of the AHCCCS Medical Policy Manual <http://www.azahcccs.gov/Regulations/OSPpolicy/>

Policy 310–N, Laboratory: Genetic Testing Provisions

The Laboratory Policy was modified to include medical necessity criteria related to genetic testing. Please refer to the section of Policy labeled as Limitations: Genetic Testing Provisions.

Genetic testing will only be covered if the testing is necessary to differentiate between treatment options. Genetic testing is not covered to determine specific diagnosis or syndromes when such diagnosis would not significantly alter the medical treatment of the member.

Genetic testing is not covered for purposes of current or future family planning. Genetic testing is not covered to determine if members carry a hereditary predisposition to cancer or other diseases. Genetic testing is also not covered for members diagnosed with cancer to determine whether their particular cancer is due to a hereditary genetic mutation known to increase the risks of developing that cancer.

Policy 310-T, Physician Services: Allergic Immunotherapy

The Physician Services Policy was modified to include medical necessity criteria related to allergic immunotherapy. Please refer to the section of policy labeled as Limitations: Allergic Immunotherapy.

AHCCCS will no longer cover allergic immunotherapy (testing, treatment, injections) **for adults (21 years of age and older)** except in limited circumstances where an absence of therapy may be life threatening.

Provider Network Operations

Phone 602.778.1800 or 866.560.4042 (Options in order: 5, 7)

Fax 602.778.1875

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Allergy testing is only covered in those instances when a member has either sustained an anaphylactic reaction to an unknown allergen or has exhibited such a severe allergic reaction (e.g., severe facial swelling, breathing difficulties, epiglottal swelling, extensive urticaria, etc.) that it is reasonable to assume further exposure to the unknown allergen may result in a life-threatening situation. In such instances, allergy testing is covered to identify the unknown allergen.

These limitations do not preclude coverage of over-the-counter medications or prescriptions intended to treat allergy symptoms.

The Physician Services Policy also addresses Genetic Subspecialists. These providers are limited by the provisions included in Policy 310-N Laboratory “Genetic Testing”.

Policy 310-Z, Sleep Studies (Polysomnography)

The Sleep Studies Policy was completely rewritten to include “Indications and Limitations”. AHCCCS added the requirement that if positive air pressure titration is indicated, a “split night” study must be performed. The testing may only be completed over two separate nights if there are clinical indications preventing a “split night” study (in a split night study, the sleep study is performed during the first half of the night and positive air pressure system titration is performed during the second half of the night).

Policy 310-EE, Negative Pressure Wound Therapy

Negative Pressure Wound Therapy is a new Policy. This Policy sets medical necessity criteria for negative pressure wound therapy for all populations. The Policy includes criteria related to initiating coverage, continued coverage, and when coverage ends. The Policy also includes a category of limitations on coverage.

NOTE: Should members wish to pay for non-covered services, the following needs to occur according to R9-22-702D. The provider initiates a document designating agreement of financial responsibility for member signature prior to the rendering of the service. The document must include the following information: service to be delivered, cost estimate, language regarding member understanding and agreement regarding financial liability.

Please contact Provider Network Operations at the number below with any questions.

Thank you!