

SECTION VI: Covered Services

COVERED SERVICES

Services covered by AHCCCS/DDD for Care1st members are determined by the AHCCCS Administration and/or DES/DDD. Covered services must be medically necessary. For services that require prior authorization, please reference the Prior Authorization Guidelines.

Below is a reference list of AHCCCS-covered services. Some of these services are limited in scope or duration or available to certain populations only. The list is followed by a more detailed description of selected services that have restrictions or require additional explanation.

1. Doctor visits
2. Visits with a nurse practitioner or physician's assistant
3. Emergency care
4. Emergency transportation
5. Health check-ups including screening and assessments
6. Nutritional evaluations
7. Inpatient hospital care (limited to a maximum of 25 days per contract year for members over the age of 21 (ie. October 1st through September 30th))
8. Outpatient hospital care
9. Rehabilitation services in accordance with AHCCCS and DES/DDD rules
10. Hospice care for all ages
11. Radiology, medical imaging, lab work and other tests
12. Chiropractic care (for members under age 21 and "QMB" members)
13. Maternity care
14. Family Planning
15. Well child care (EPSDT care) including immunizations
16. Behavioral health services (see Section VII)
17. Most medically necessary supplies and equipment
18. Prescriptions
19. Home health services
20. Nursing home care (if used instead of hospitalization) up to 90 days per contract year (ie. October 1st through September 30th)
21. AHCCCS approved organ and tissue transplants and related drugs
22. Dialysis
23. Preventive dental care and treatments for members under age 21
24. Medical and surgical services related to dental (oral) care and certain pre-transplant services and prophylactic extraction of teeth for members over age 21

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25. Vision care including eyeglasses for members under age 21
26. Vision care for members age 21 and over following cataract surgery and for emergency eye conditions
27. Hearing evaluations and treatment (hearing aids) for members under age 21
28. Hearing evaluations for members age 21 and over
29. Medically necessary foot care
30. Medically necessary transportation
31. Outpatient Physical Therapy (limited to 15 visits per contract year (10/1-9/30) for adult members 21 years and older)

In addition to the services above, the following services are also covered for DDD members:

- Adaptive aids /certain specialized medical equipment
- Endodontic services are only considered medically necessary when provided on functional teeth that have a favorable prognosis for success.

CHIROPRACTIC SERVICES

Covered services are available for members under age 21 and “QMB” (Qualified Medicare Beneficiaries). Coverage is limited to manual manipulation of the spine to correct subluxation.

CHILDREN’S REHABILITATIVE SERVICES (CRS) - (CARE1ST AHCCCS ONLY)

CRS provides services for children from birth to their 21st birthday. CRS services help improve the quality of life for medically qualified children with specific disabling conditions and promote the potential for functional improvement. Children who have one or more of the 100+ diagnoses that CRS provides services for, and who have an AHCCCS health plan for their primary insurance coverage, must be seen in CRS clinics and receive services through CRS, rather than the AHCCCS health plan, for the CRS condition. In addition, drugs related to the CRS condition must be obtained through CRS authorized pharmacies.

All children seen in the CRS clinics are required to have an assigned primary care physician (PCP) with their health plan to follow and coordinate the care of the child. Having an assigned PCP adds to the quality of care for children with special health care needs.

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A provider's office is the best source for the application where the additional documentation and information may be found. The following information is needed when sending an application to CRS: Patient Name, Patient Date of Birth; Patient Address; Patient Phone Number; and Parent(s) /Guardian(s) Name; PCP Name; PCP Address; PCP Phone Number; and any supporting documentation in regards to the child's condition. The parent/guardian does not have to sign the application prior to sending.

Along with the application, documentation of the condition must be sent to CRS for review. Examples of covered conditions and required documentation are listed below. Please note that this is not an all-inclusive list of covered conditions covered, but is useful for reference purposes. If there is a question regarding whether or not a child should be referred to CRS, please contact the Care1st CRS Coordinator or submit the application to CRS. CRS will send notification to the PCP and/or referring provider via mail regarding the decision once the application review process is completed.

Conditions Covered	Information to Accompany Application to CRS
Ambiguous Genitalia	Clinical Notes: Specialty notes
Amino Acid Metabolic Disorder	Lab test results
Amniotic Band Syndrome	Clinical notes
Biliary Atresia	Clinical notes : lab test results
Cerebral Palsy	Clinical notes from Neurologist
Cleft Lip/Palate: Deformity	Clinical notes: specialty notes
Club foot/hand	Clinical notes: x-ray reports if done
CNS Degenerative Disease	Neurology notes
Congenital Hip dysplasia/ Dislocation (not click)	Clinical notes: x-ray reports if done
Craniosynostosis	MRI/CT reports: Clinical notes
Cystic Fibrosis	Clinical notes: Sweat Test results
Diabetes INSIPIDUS (not Mellitus)	Clinical notes: lab test
Ectopic Ureter	VCUG/ Renal US report: Clinicals

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Conditions Covered	Information to Accompany Application to CRS
GI Track anomalies (all MAJOR anomalies)	Surgical reports: Specialty report
Hydrocephalus	CT/MRI reports: Surgical report
Hydronephrosis	VCUG/Renal US reports: Clinicals
Hyper/Hypo Thyroidism	Lab test: Clinical notes
Leg Length Discrepancy	X-ray reports: Clinicals
Legg-Calve-Perthes Disease	Orthopedic Notes: X-ray reports
Limb Malformation of upper/lower extremities	Clinical Notes: X-ray reports if done
Major Cardiac Disorders (not murmurs)	Cardiology notes and Cardiac Echo if done
Metabolic Disease	Lab reports: Clinicals
Multicystic Kidney Disease	VCUG/ Renal US ; Clinicals
Muscular Dystrophy	Neurology Notes
Neurofibromatosis	MRI/CT reports: clinicals describing size, shape, number, size & freckling
Osteogenesis Imperfecta	Clinical notes: x-ray reports
Poly/Syndactyly	Clinical Notes
Rheumatoid Arthritis	Specialty notes: lab results: ANA results
Rickets	Clinical notes
Retinopathy of Prematurity (ROP)	Ophthalmology notes giving degree of visualization
Scoliosis	X-ray report: Clinical notes

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DENTAL

AHCCCS COVERED DENTAL SERVICES

Dental services are covered for all EPSDT members age 20 and younger. This includes medically necessary dental services such as dental screenings, preventive services, therapeutic dental services, medically necessary dentures, and pre-transplantation dental services.

Effective October 1, 2010 AHCCCS covers medical and surgical services related to dental (oral) care for members 21 years and older. Covered dental services must be related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw. Covered dental services include examining the mouth, x-rays, care of fractures of the jaw or mouth, giving anesthesia and pain medications and/or antibiotics. Certain pre-transplant services and prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head is also covered.

DENTAL GUIDELINES EFFECTIVE FOR DATES OF SERVICE

Advantica Administrative Services, Inc. (Advantica) manages the dental benefits provided to Care1st members on behalf of Care1st.

Prior authorizations, claim submissions and claim inquiries are submitted to Advantica.

1. The dental “At a Glance Guidelines” provides detailed information regarding prior authorization requirements and claim submission requirements regardless of the cost of the total treatment plan. For the most current “At a Glance Guidelines” or detailed information on the clinical guidelines and criteria visit the Advantica web site www.advanticedental.com or contact Advantica at 800.429.0495.
2. All Care1st members (except family planning members with a 55XX rate code) may self refer to a general dentist.
3. Prior authorization requests must be submitted with documentation as outlined on the “At a Glance Guidelines” via the following methods:

Advantica’s website:

www.advanticedental.com

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Mail:

Advantica
Suite 14
Prior Auth Department
9735 Landmark Parkway Drive
St. Louis, MO 63127

EMERGENCY SERVICES

DEFINITION

“Emergency Medical Condition” means a medical condition manifesting itself by the sudden onset of symptoms of acute severity, which may include severe pain such that a reasonable person would expect that the absence of immediate medical attention could result in (1) placing the member’s health in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

EMERGENCY CARE

Care1st members are entitled to access emergency care without prior authorization. However, Care1st requires that when an enrollee is stabilized but requires additional medically-necessary health care services, that providers notify Care1st prior to, or at least during the time of rendering these services. Care1st wishes to assess the appropriateness of care and assure that care is rendered in the proper venue.

LIFE THREATENING OR DISABLING EMERGENCY

Delivery of care for potentially life threatening or disabling emergencies should never be delayed for the purposes of determining eligibility or obtaining prior authorization. These functions should be done either concurrently with the provision of care or as soon after as possible.

BUSINESS HOURS

In an emergency situation, if a member is transported to an emergency department (ED), the ED physician will contact the member’s PCP as soon as possible (post stabilization) in order to give him/her the opportunity to direct or participate in the management of care.

MEDICAL SCREENING EXAM

Hospital EDs under Federal and State Laws are mandated to perform a medical screening exam (MSE) on all patients presenting to the ED. Emergency services include additional screening examination and evaluation needed to determine if a psychiatric emergency medical condition exists. Care1st will cover emergency services necessary to screen and stabilize members without prior authorization in cases where a prudent layperson acting reasonably would have believed that an emergency medical condition existed.

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AFTER BUSINESS HOURS

After regular Care1st business hours member eligibility is obtained and notification is provided by calling the telephone number on the member ID card, which is the regular Member Services telephone number. During these hours the number connects to a 24-hour information service, which is available to members as well as to providers. Nurse triage services are available in the event that a member calls for advice relating to a clinical condition that they are experiencing during, before or after business hours. In these cases the member will be given advice or directed to go to the nearest urgent care facility, ED, or to call 911 depending on the circumstances and the nurse triage protocols.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

DESCRIPTION

EPSDT is a state-administered, federal program which provides comprehensive health care (as defined in Arizona Administrative Code R9-22-213) through primary prevention, early intervention, diagnosis and medically necessary treatment of physical and behavioral health problems for enrolled AHCCCS members under 21 years of age. EPSDT also provides for all medically necessary services to treat or ameliorate physical and behavioral health disorders, a defect, or a condition identified in an EPSDT screening. General limitations and exclusions, other than the requirement for medical necessity, do not apply to EPSDT services.

AMOUNT, DURATION AND SCOPE

EPSDT screening services are provided in compliance with the periodicity requirements of Title 42 of the Code of Federal Regulations (42 CFR) Section 441.58. Care1st is required to ensure members receive required health screenings in compliance with the AHCCCS periodicity schedule. AHCCCS' periodicity schedule is intended to meet reasonable and prevailing standards of medical and dental practice and specifies screening services at each stage of the child's life. The service intervals represent minimum requirements, and any services determined by a primary care provider to be medically necessary should be provided, regardless of the interval.

SCREENING REQUIREMENT

Comprehensive periodic screenings must be conducted according to the time frames identified in the AHCCCS Periodicity Schedule, and inter-periodic screenings as appropriate for each member. The AHCCCS Periodicity Schedule is based on recommendations by the Arizona Medical Association and is closely aligned with guidelines of the American Academy of Pediatrics. EPSDT screenings must include the following:

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1. A comprehensive health and developmental history (including physical, nutritional, and behavioral health assessments). Beginning January 2006, it is recommended that any baby admitted to the Nursery Intensive Care Unit (NICU) after birth should have a developmental screening using the Parents' Evaluation of Developmental Status (PEDS) Tool. This tool should be used during all EPSDT visits from 0-8 years of age. Prior to implementation of this tool in your office, the provider must be trained in the administration of the tool and Care1st must be notified. Training materials are available on the PEDS website (www.pedstest.org). Additional information regarding PEDS can be found on the AzAAP website www.azaap.org. Further instructions will be given regarding billing requirements which will allow for additional reimbursement for completion of the PEDS Tool. Please contact the EPSDT Unit or your Provider Network Representative for more information.
2. A comprehensive unclothed physical examination
3. Appropriate immunizations according to age and health history
4. Laboratory tests (including blood lead screening assessment, see handbook for requirements, 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)
5. Health education
6. Appropriate oral health screening, intended to identify gross tooth decay or oral lesions, which is conducted by a physician, physician's assistant, or nurse practitioner
7. Appropriate vision, hearing, and speech testing and diagnosis, as well as treatments for defects in vision and hearing, including provision of eyeglasses and hearing aids. Appropriate therapies including speech therapy are also covered under EPSDT, and
8. Tuberculin skin testing as appropriate to age and risk. Children at increased risk of tuberculosis (TB) include those who have contact with persons:
 - 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, and

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- d. Traveling/immigrating from or with significant contact with indigenous persons from endemic countries.

EPSDT SERVICE STANDARDS

EPSDT services must be provided according to community standards of practice and the AHCCCS periodicity schedule. The EPSDT and Dental periodicity schedules can be found at

<http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap400.pdf>, pp.83-87. AHCCCS EPSDT tracking forms are used to document services provided in compliance with AHCCCS standards. The “yellow” copy of the tracking forms is submitted to Care1st to the attention of the EPSDT Team. Age-specific EPSDT tracking forms may be ordered by calling Provider Network Operations and submitting a completed EPSDT Order Form (available on our website under Forms of the Provider drop down menu). Tracking forms may also be downloaded at <http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/AppendixB.pdf>

Offices implementing electronic medical records please note: the EPSDT portion MUST adhere to and contain all of the components found on the EPSDT tracking form. A copy of the electronic medical record MUST be submitted to Care1st as a replacement for the current “yellow copy” that is submitted.

EPSDT providers must adhere to the following specific standards and requirements:

1. **Immunizations** - EPSDT covers all child and adolescent immunizations as specified in the AHCCCS Periodicity Schedule. All appropriate immunizations must be provided to bring and maintain each EPSDT member's immunization status up to date. Providers must participate in the Arizona Department of Health Service Vaccines For Children (VFC) program to ensure the delivery of immunization services, if seeing members under the age of 19. Providers must re-enroll each year in the VFC Program. Through the VFC program the federal government purchases, and makes available to the states free of charge, vaccines for children under the age of 19 who are Title XIX eligible, Native American, or Alaskan Native, not insured, or whose insurances does not cover immunizations. Immunizations must be provided according to the Advisory Committee on Immunization Practices Recommended Schedule which may be found at www.cdc.gov/vaccines. Additionally, all immunizations given must be reported to the Arizona State Immunization Information System (ASIIS). VFC can be reached at 602.364.3642. ASIIS can be reached at 1.877.491.5741.
2. **Eye examinations and prescriptive lenses** - EPSDT covers eye examinations as appropriate to age according to the AHCCCS Periodicity Schedule and as medically necessary. Prescriptive lenses are provided to correct or ameliorate defects, physical illness and conditions discovered by EPSDT screenings, subject to medical necessity.

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3. **Blood Lead Screening** - EPSDT covers blood lead screening. All children are considered at risk and must be screened for lead poisoning. All children must receive a screening blood lead test at 12 months and 24 months of age. Children between the ages of 36 months and 72 months of age must receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test result equal to or greater than 10ug/dl obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample. A verbal risk assessment must be completed at each EPSDT visit for children ages 6 months through 72 months (6 years) to assist in determining risk. Appropriate follow-up must be provided.
4. **Organ and tissue transplantation services** - EPSDT covers medically necessary non-experimental organ and tissue transplants approved for Title XIX reimbursement in accordance with respective transplant policies as noted in Chapter 300 of the AHCCCS Medical Policy Manual.
5. **Nutritional Assessment and Nutritional Therapy** - Nutritional Assessments are conducted to assist members whose health status may improve with nutrition intervention. AHCCCS covers the assessment of nutritional status provided by the member's primary care provider (PCP) as a part of the EPSDT screenings specified in the Periodicity Schedule and on an inter-periodic basis as determined necessary by the member's PCP. AHCCCS also covers nutritional assessment provided by a registered dietitian when ordered by the member's PCP. AHCCCS covers Nutritional Therapy (enteral, parenteral, oral) when determined medically necessary to provide either complete daily dietary requirements or to supplement daily nutritional and caloric intake.

Commercial Oral Supplemental Nutritional Feeding: 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.

- a. PA is required for commercial oral nutritional supplements unless the member is also currently receiving nutrition through enteral or parenteral feedings. PA is not required for the first 30 days if the member requires commercial oral nutritional supplements on a temporary basis due to an emergent condition.
- b. Medical necessity for commercial oral nutritional supplements must be determined on an individual basis by the member's PCP or attending physician, using at least the criteria specified in this policy. The PCP or attending physician must use the AHCCCS approved form, "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements" to

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obtain PA from Care1st. The “Certificate of Medical Necessity for Commercial Oral Nutritional Supplements” form may be found at <http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap400.pdf>, pp. 90-91.

- c. The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must document that the PCP or attending physician has provided nutritional counseling as a part of the EPSDT services provided to the member. The documentation must specify alternatives that were tried in an effort to boost caloric intake and/or change food consistencies before considering commercially available nutritional supplements for oral feedings, or to supplement feedings.

The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must indicate which criteria were met when assessing the medical necessity of providing commercial oral nutritional supplements. At least two of the following criteria must be met:

1. The member is at or below the 10th percentile on the appropriate growth chart for their age and gender for three months or more
 2. The member has reached a plateau in growth and/or nutritional status for more than six months (prepubescent)
 3. The member has already demonstrated a medically significant decline in weight within the past three months (prior to the assessment)
 4. The member is able to consume/eat no more than 25% of his/her nutritional requirements from age-appropriate food sources
 5. Absorption problems as evidenced by emesis, diarrhea, dehydration, and/or weight loss and intolerance to milk or formula products has been ruled out, or
 6. The member requires nutritional supplements on a temporary basis due to an emergent condition; i.e. post-hospitalization. (PA is not required for the first 30 days.)
 7. The member is at risk for regression due to chronic disease or condition.
6. **Oral Health Services** - As part of the physical examination, the physician, physician's assistant or nurse practitioner should perform an oral health screening. A screening is intended to identify gross dental or oral health lesions, but 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 should be made according to the following timeframes:

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Category	Recommendation	Criteria
Urgent	Within 24 hours	Pain, infection, swelling and/or soft tissue ulceration of approximately two weeks duration or longer.
Early	Within three weeks	Decay without pain, spontaneous bleeding of the gums and/or suspicious white or red tissue areas.
Routine	Next regular checkup	None of the above problems identified.

An oral health screening should be part of an EPSDT screening conducted by a PCP; however, it does not substitute for examination through direct referral to a dentist. PCPs are expected to refer EPSDT members for appropriate services based on needs identified through the screening process and for routine dental care based on the periodicity schedule. Evidence of this referral should be documented on the EPSDT form. In addition to PCP referrals, EPSDT members are allowed self-referral to a dentist who is included in the Contractor provider network.

FAMILY PLANNING EXTENSION SERVICES

This program (also known as SOBRA Family Planning Services-FPS) provides family planning services only for a maximum of 24 months to SOBRA women whose pregnancy has ended and who are not otherwise eligible for full Title XIX services. Members' eligibility for the Family Planning Extension Program will be re-determined annually. These members are eligible for the Family Planning services listed below. These members are not covered for any other services provided by Care1st, unless that service is related to a family planning service. If your Family Planning Services member requires primary care services, which may include members determined to have a sexually transmitted disease, you may then direct them to no/low cost clinics or agencies. Please contact the Quality Management Department or your Provider Network Representative for assistance.

FAMILY PLANNING SERVICES

Family planning services for male and female members are covered when provided by physicians or practitioners to members who voluntarily choose to delay or prevent pregnancy. Physicians and other practitioners should discuss and document in the medical record that each member of reproductive age has been notified verbally or in writing of the availability of family planning services. Family planning and family planning extension services include covered medical, surgical, pharmacological and laboratory benefits specified below. Covered services also include the provision of

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accurate information and counseling to allow members to make informed decisions about the specific family planning methods available.

Family planning services for members eligible to receive full health care coverage and members eligible to receive family planning extension services may receive the following medical, surgical, pharmacological, and laboratory services:

1. Contraceptive counseling, medication, supplies, including, but not limited to: oral and injectable contraceptives, intrauterine devices, diaphragms, condoms, foams and suppositories. Prior to insertion of subcutaneous implantable contraceptives, the family planning provider must provide proper counseling to the eligible member to minimize the likelihood of a request for early removal. Counseling information is to include the statement to the member indicating if the device is removed within two years of insertion, the member may not be an appropriate candidate for reinsertion for at least one year after removal.
2. Associated medical and laboratory examinations 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, and
5. Postcoital emergency oral contraception within 72 hours after unprotected sexual intercourse. Note: Mifepristone also known as Mifeprex or RU 486 is not postcoital emergency oral contraception

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

1. Infertility services including diagnostic testing, treatment services or reversal of surgically induced infertility
2. Pregnancy termination counseling, or
3. Pregnancy terminations including the use of Mifepristone (Mifeprex or RU 486) and hysterectomies

Tubal ligations and vasectomies are covered for members age 21 or over who are mentally competent. Prior authorization is required for these services. A federally mandated Sterilization Consent Form must be signed at least 30 days before the procedure. The consent form is valid for up to 180 days.

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SPECIAL CIRCUMSTANCES FOR DDD MEMBERS

DDD member requests for tubal ligations or vasectomy must be prior approved by Care1st and the DES/DDD Medical Director. DES/DDD must determine the member's competency to make an informed decision, or the legality of guardianship, prior to sterilization.

Requests for Special Circumstances for DDD members must be made to the Care1st CMO. The CMO will review the request to insure that all required documentation is present prior to forwarding the information to the DES/DDD Medical Director.

Elective sterilization by hysterectomy will not be approved. Elective hysterectomy due to medical necessity requires prior authorization by Care1st and the DES/DDD Medical Director.

Emergency hysterectomies, or any other emergency procedure which renders the DDD member sterile must be reported to Care1st who in turn must report the information to DES/DDD within 48 hours of the procedure. Documentation from the provider regarding the emergency circumstances should immediately follow the reporting of the procedure to Care1st.

HOME HEALTH

Home health care is a covered service when members require part-time or intermittent care but do not require hospital care under the daily direction of a physician. Twenty-four (24) hour care is not a covered service.

HEARING

Hearing evaluation and treatment (hearing aids) are covered for members under age 21. Hearing evaluations are covered for member age 21 and older.

LABORATORY

Sonora Quest is contracted for all outpatient laboratory work for all lines of business, lab draws in the office must be sent to Sonora Quest for processing. Service locations are available at www.sonoraquest.com by clicking the patient service center locator tab. Web-based patient service center appointment scheduling is also available and offers members the ability to schedule an appointment for a convenient day and time, resulting in reduced wait time upon arrival at a patient service center. The web based scheduling

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system is available 24-hr a day. Walk-in appointments are still available during scheduled hours of operation as well, although appointments are encouraged.

MATERNITY CARE

SERVICES INCLUDED IN THE TOTAL OB PACKAGE

<ul style="list-style-type: none"> • Physical Exams • Initial and subsequent history • Weight and blood pressure • Breast stimulation studies • Genetic counseling • Artificial rupture of membrane • Follow up visits • Fetal scalp monitoring • Induction of labor • Delivery (includes multiple births) • 5+ prenatal visits & 1 post partum (pap smear included) are included in Total OB package • Laboratory services and handling fees 	<ul style="list-style-type: none"> • Family planning • Maternity counseling • Nutritional Evaluation • Non-stress test • Inpatient services • Wet preps and wet mounts • External cephalic versions • Risk Screening per ACOG Standards • All Prenatal Visits, including EPSDT Visits • Delivery (includes multiple births) • WIC Referrals for Medically Eligible Members
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SERVICES EXCLUDED FROM THE TOTAL OB PACKAGE & REIMBURSED SEPARATELY - Prior authorization may be required

<ul style="list-style-type: none"> • Amniocentesis • Amnioinfusion (requires prior authorization) • OB Ultrasound 	<ul style="list-style-type: none"> • Post-partum Tubal Ligation (requires prior authorization) • RhoGAM Injection • Surgical Assist
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HIGH RISK PRENATAL HOME CARE INFUSION

Please contact our Case Management Team at 602.778.1800 x8336 for assistance with high risk members.

MATERNITY CARE APPOINTMENT SCHEDULING

<ul style="list-style-type: none"> • First trimester • Second trimester • Third trimester • High risk pregnancies 	<ul style="list-style-type: none"> • Within 14 days of request • Within 7 days of request • Within 3 days of request • Within 3 days of identification of high risk by the health plan or maternity care provider, or immediately if an emergency exists
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Return appointments are scheduled per the ACOG standards indicated below:

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- Monthly through 28 weeks
- Bi-weekly between 29 and 36 weeks
- Weekly after the 36th week

WELL WOMAN CARE

A well woman exam includes (as appropriate for age): pap smear, Chlamydia screening and referral for a mammogram. Bill with the appropriate preventive care codes. Women may self-refer to any contracted OB/GYN or be directly referred by their PCP.

Effective October 1, 2010, AHCCCS no longer reimburses for well exams for members age 21 years and older. Well exams are defined as: “Physical examinations in the absence of any known disease or specific medical complaint by the patient precipitating the examination.” Office visits for evaluation or treatment of medical conditions continue to be covered. Well exams for members under the age of 21 remain a covered benefit.

Although AHCCCS no longer reimburses for well exams, AHCCCS will continue to cover pap smears and mammograms. Mammograms are distinct procedures described by CPT codes and are separately payable. There are no CPT codes that describe the collection of a pap smear. However, HCPCS code Q0091 may be used to describe this procedure. A pelvic exam may be performed during any office visit, even if the pelvic exam is unrelated to the underlying reason for the visit. For example, a physician seeing a patient for a sore throat, cough or back pain may perform a pelvic exam to obtain a specimen for a pap smear. Office visits for family planning purposes also continue to be covered and may include a pelvic exam and pap smear. The Q0091 code may be reported without an associated office visit code.

OPTOMETRY/VISION

Covered services are available for members under age 21. Members may self refer to *Nationwide Vision*. Covered services per contract year (i.e. October 1st through September 30th) include:

Covered services include:

- 1 exam
- 1 pair of prescription lenses or additional frames and glasses if medically necessary
- 1 repair of prescription lenses

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ORTHOTICS AND PROSTHETICS

Orthotic and Prosthetic services are covered when medically indicated and prescribed by a contracted provider for members under the age of 21.

Effective October 1, 2010, orthotic services are no longer a covered benefit for adult members 21 years and older. Prosthetic services, except for microprocessor controlled lower limbs and microprocessor controlled joints for lower limbs, for adult member 21 years and older continue to be a covered benefit.

PHARMACY

FORMULARY

The Care1st Formulary is available online at our website www.care1st.com/az. You may also contact Provider Network Operations for a copy. Please ensure that your office is prescribing medications listed on the current formularies. Before submitting the Pharmacy Prior Authorization Request Form for a non-formulary medication, consider all formulary alternatives. Prior authorization requests and supporting documentation are faxed to 602.778.1838.

MedImpact is our Prescription Benefit Manager and they manage all prescription drug transactions and pharmacy networks for all lines of business.

SPECIALTY MEDICATIONS PURCHASING PROGRAM

Specialty injectable drugs may be obtained through our contracted vendor, BioScrip. Please use the following procedure to procure mail-order specialty drugs:

Prior Authorization Process

- Complete the Pharmacy Prior Authorization Request and fax to us at 602.778.1838.
- Once approved, the Pharmacy Department will fax back the approval to the practice.
- The practice then completes the BioScrip request form (form is provided by the Pharmacy Team at the time of approval) and faxes the script and the completed BioScrip form to BioScrip at 866.488.5809. The phone number for BioScrip is 877.316.8921.
- BioScrip completes the order and ships the medication.

Prior authorization requests must first come to the health plan before an order is placed. If prior authorization is not obtained before the order is placed, the plan decision and patient care may be delayed.

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*This program does not include vaccines. In addition, all unclassified drugs (i.e. J3490, J9999) require prior authorization and will be evaluated by the Prior Authorization Department on a case by case basis for approval and reimbursement. Contact Pharmacy Prior Authorization at 602.778.1800 (Options 5, 5) if you have any questions.

PODIATRY

The following medically necessary podiatric services are covered for members under the age of 21:

- Casting for the purpose of construction or accommodating orthotics
- Orthopedic shoes that are an integral part of a brace
- Foot care for patients with severe systemic disease which prohibits care by a nonprofessional person
- Bunions with underlying neuroma

Non-covered services include:

- Treatment of fungal (mycotic) infections without underlying systemic disease
- Painful bunions without laceration
- Foot and ankle services provided by a podiatrist for members 21 years and older

RADIOLOGY

Radiology services required in the course of diagnosis, prevention, treatment and assessment are covered services.

REHABILITATION

OCCUPATIONAL THERAPY

Occupational therapy services are medically prescribed treatments to improve or restore functions which have been impaired by illness or injury, or which have been permanently lost or reduced by illness or injury. Occupational therapy is intended to improve the member's ability to perform those tasks required for independent functioning.

Amount, Duration and Scope: Care1st covers medically necessary inpatient occupational therapy services for all members. Outpatient occupational therapy services are covered only for members under the age of 21 receiving EPSDT services, KidsCare members and Arizona Long Term Care System (ALTCS) members.

Inpatient occupational therapy consists of evaluation and therapy. Therapy services may include:

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- a. Cognitive training
- b. Exercise modalities
- c. Hand dexterity
- d. Hydrotherapy
- e. Joint protection
- f. Manual exercise
- g. Measuring, fabrication or training in use of prosthesis, arthrosis, assistive device, or splint
- h. Perceptual motor testing and training
- i. Reality orientation
- j. Restoration of activities of daily living
- k. Sensory re-education, and
- l. Work simplification and/or energy conservation

PHYSICAL THERAPY

Physical therapy is a covered service when provided by, or under the supervision of, a registered physical therapist to restore, maintain or improve muscle tone, joint mobility or physical function.

Amount, Duration and Scope: Care1st covers medically necessary physical therapy services for all members. Physical therapy is covered on an inpatient and outpatient basis. Effective October 1, 2010 outpatient physical therapy visits are limited to 15 visits per contract year (10/1-9/30) for adult members 21 years and older.

Outpatient physical therapy is not covered as a maintenance regimen.

SPEECH THERAPY

Speech therapy is the medically prescribed provision of diagnostic and treatment services provided by, or under, the direct supervision of a qualified speech pathologist.

Amount, Duration and Scope: Care1st covers medically necessary speech therapy services provided to all members who are receiving inpatient care at a hospital (or a nursing facility) when services are ordered by the member's PCP. Speech therapy provided on an outpatient basis is covered only for members under the age of 21 receiving EPSDT services, KidsCare and ALTCS members.

Inpatient speech therapy consists of evaluation and therapy. Therapy services may include:

- a. Articulation training
- b. Auditory training
- c. Cognitive training
- d. Esophageal speech training

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- e. Fluency training
- f. Language treatment
- g. Lip reading
- h. Non-oral language training
- i. Oral-motor development, and
- j. Swallowing training

DES/DDD/ALTCS members may require therapies – rehabilitative and/or habilitative - to maintain, correct, or ameliorate a problem discovered by EPSDT screen, exam or evaluation. Care1st provides funding for EPSDT-identified rehabilitation services using a teaching model approved by DES/DDD. DES/DDD provides funding for complementary rehab therapies. PCPs with DES membership should contact Care1st's DDD Liaison for additional information.

TRANSPORTATION

Medically necessary transportation to and from contracted providers is a covered services for members who are not able to arrange or pay for transportation. Members are responsible for contacting Member Services to arrange transportation 3 days prior to a routine appointment.

NON-COVERED SERVICES

In response to significant fiscal challenges facing the State and continuing growth in the Medicaid population, effective *October 1, 2010 and October 1, 2011*, AHCCCS implements several changes to the adult benefit package. The changes to the benefit package impact ***all*** adults 21 years of age and older, unless otherwise specified.

Complete information regarding benefit changes can be found on the AHCCCS website:

<http://www.azahcccs.gov/reporting/legislation/sessions/2010/BenefitChanges.aspx>.

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AHCCCS EXCLUDED BENEFITS TABLE FOR ADULTS 21 YEARS AND OLDER EFFECTIVE 10/1/2010

Insulin Pumps	AHCCCS will eliminate coverage of Insulin pumps. Supplies, equipment maintenance and repair of component parts will remain a covered benefit. Documentation that establishes the need to replace a component not operating effectively must be provided at the time prior authorization is sought.	E0784
Percussive Vests	AHCCCS will eliminate coverage of percussive vests. Supplies, equipment maintenance and repair of component parts will remain a covered benefit. Documentation that establishes the need to replace a component not operating effectively must be provided at the time prior authorization is sought.	E0483
Bone-Anchored Hearing Aids	AHCCCS will eliminate coverage of Bone-Anchored Hearing AID (BAHA). Supplies, equipment maintenance and repair of component parts will remain a covered benefit. Documentation that establishes the need to replace a component not operating effectively must be provided at the time prior authorization is sought.	L8690, L8692
Cochlear Implants	AHCCCS will eliminate coverage of cochlear implants. Supplies, equipment maintenance and repair of component parts will remain a covered benefit. Documentation that establishes the need to replace a component not operating effectively must be provided at the time prior authorization is sought.	L8614
Prosthetics	AHCCCS is limiting this benefit change to apply only to the elimination of microprocessor controlled lower limbs and microprocessor controlled joints for lower limbs.	L5856, L5857, L5858 and L5973
Orthotics	AHCCCS will eliminate coverage of orthotics. Orthotics are described as devices prescribed by a physician or other licensed professionals of the healing arts to support a weak or deformed portion of the body. AHCCCS considers orthotics to generally be items in codes L0001-L4999 with some exceptions. (There are some supplies which are also listed in this range of orthotic codes. Those supplies will not be eliminated.)	L0001 - L4999, Refer to Attachment A-1 on the AHCCCS website for exceptions

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	Equipment maintenance and repair of component parts will remain a covered benefit. Documentation that establishes the need to replace a component not operating effectively must be provided at the time prior authorization is sought.	
Emergency Dental Service	Emergency adult dental services are eliminated. However, in accordance with federal law and the State Plan, AHCCCS will cover medical and surgical services furnished by a dentist only to the extent that 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. For members 21 years of age and older, the services must be related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw. The covered services include 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. Certain pre-transplant services (e.g. dental cleanings, fillings, restorations, extractions) and prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head are also covered.	Refer to Attachment A-2 on the AHCCCS website for list of dental covered codes
Services by Podiatrist	Foot and Ankle Services provided by a podiatrist are no longer covered. Those services may be reimbursed if rendered by another clinician such as a physician, NP, or PA.	Not Applicable
Well Exams	Well visits are no longer covered. Well exams means physical examinations in the absence of any known disease or symptom or any specific medical complaint by the patient precipitating the examination. However, pap smears, mammograms, and colonoscopies will still continue to be covered.	CPT codes: 99385 - 99387, 99395 - 99397 and S5190 OR professional claim (regardless of procedure code) with primary dx of V72.31 V70.0 V70.9
Transplants (Coverage Restored 4/1/11)	Effective 10/1/2010, the following non-experimental transplants will not be covered (excluded from coverage) for persons age 21 years and older. Exception: members who are in the "prep and transplant" phase or one of the post-transplant care phases for one of these transplants prior to 10/1/2010 will remain covered for the transplant and subsequent care. (This	Specific transplant case types are eliminated.

SECTION VI: Covered Services

means that prior to October 1, the tissue has been harvested, the organ has been procured, or the transplant surgery has been performed

Transplants not covered

- Pancreas after kidney transplants
- Lung transplants
- Allogeneic unrelated hematopoietic cell (bone marrow) transplants
- Liver transplants for members with a diagnosis of Hepatitis C
- Heart transplants for non-ischemic cardiomyopathies
- Any other transplants not listed as covered.

“Non-ischemic cardiomyopathy” is defined as a condition in which the underlying cardiac abnormality has not resulted in irreversible permanent damage to the heart muscle. Members with “non-ischemic cardiomyopathy” have sufficient cardiac function to circulate adequate volumes of blood and oxygen to the heart muscle and other body organs.

"Ischemic cardiomyopathy" is defined as an underlying cardiac abnormality that causes insufficient blood flow to the heart, resulting in permanent damage to the heart muscle. There are several causes of ischemic cardiomyopathy, including; 1) atherosclerotic coronary artery disease, which results in narrow blood vessels in the heart; 2) ventricular hypertrophy that impedes blood flow due to compression of arteries within the heart muscle; 3) heart failure with an ejection fraction that is not sufficient to provide adequate blood and oxygen to the heart muscle. The term "ischemic cardiomyopathy" when used in the context of this benefit restriction does not imply that the underlying cause of the cardiac abnormality is restricted to ischemia; rather, it is used to denote that the underlying cardiac abnormality results in ischemia with permanent, irreversible damage to the heart muscle.

Effective 10/1/2010, transplants which are covered for persons age 21 years and older are limited to only: Heart, Liver, Kidney (cadaveric and live donor), Simultaneous Pancreas/Kidney (SPK), Autologous and Allogeneic Related Hematopoietic Cell Transplants, Cornea, and Bone. In order to be covered, the transplant must be medically necessary, not experimental, and not for the purpose of research.

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Physical Therapy	<p>Outpatient physical therapy visits are limited to 15 visits per contract year (10/1--9/30). Outpatient physical therapy refers to any occurrence of codes 97001-97546; All provider types except for 13 (Occupational Therapist) 22 – (Nursing Home); All places of service excluding 31 (Nursing Home) 32 (Nursing facility), and 33 (Custodial Care Facility); Count each unique date of service as a visit; Form Type to include OP Hospital or 1500.</p> <p>Refer to Attachment B on the AHCCCS website for more detail regarding Medicaid only members, QMB duals, and Medicare Primary (non QMB duals)</p>	Not Applicable
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AHCCCS EXCLUDED BENEFITS TABLE FOR ADULTS 21 YEARS AND OLDER EFFECTIVE 10/1/2011

Inpatient Days	<p>Inpatient days are limited to a maximum of 25 days per contract year (10/1-9/30). Each 24 hours of paid observation services also counts as 1 inpatient day.</p> <p>The following inpatient days are not included in the inpatient hospital limitation:</p> <ol style="list-style-type: none"> a. Days reimbursed under specialty contracts between AHCCCS and a transplant facility that are included within the component pricing referred to in the contract¹; b. Days related to Behavioral Health: <ol style="list-style-type: none"> i. Inpatient days that qualify for the psychiatric tier under R9-22-712.09 and reimbursed by the Administration or its contractors, or ii. Inpatient days with a primary psychiatric diagnosis code reimbursed by the Administration or its contractors, or iii. Inpatient days paid by the Arizona Department of Health Services Division of Behavioral Health Services or a RBHA or TRBHA.
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- c. Days related to treatment of conditions with diagnoses of burns or burn late effect at a governmentally-operated hospital located in an Arizona county with a population of more than 500,000 persons with a specialized burn unit in existence prior to 10/1/2011;
- d. Same Day Admit Discharge services are excluded from the 25 day limit; and
- e. Subject to approval by CMS, days for which the state claims 100% FFP, such as payments for days provided by HIS or 638 facilities.