Provider Outreach Manual

Prevention and Wellness

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Early and Periodic Screening, Diagnostic and Treatment Program

Early And Periodic Screening, Diagnostic and Treatment (EPSDT) services description

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a comprehensive child health program of prevention, treatment, correction, and improvement (amelioration) of physical and behavioral/mental health conditions for AHCCCS members under 21 years of age. The purpose of EPSDT is to ensure the availability and accessibility of health care resources, as well as to assist Medicaid members in effectively utilizing 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 AHCCCS members less than 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 USC 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. 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 which are referenced in the **AHCCCS EPSDT Periodicity Schedule** (Policy 430, Attachment A) and **AHCCCS Dental Periodicity Schedule** (Policy 431, Attachment A).

Providers must use the AHCCCS EPSDT Clinical Sample Templates (previously known as EPSDT tracking forms) or an electronic health record equivalent at every EPSDT visit. Mercy Care will continue to provide two-part carbonless EPSDT Clinical Sample Templates to providers. AHCCCS redesigned the EPSDT Clinical Sample Templates in February 2022. The redesign was done to provide a more targeted approach on the screenings and referrals that members are receiving.

When using the AHCCCS EPSDT Clinical Sample Templates, make sure to use the most up-to-date version of the form, as AHCCCS added some new requirements to certain age ranges. If the provider decides to submit an electronic health record system form instead, then the electronic form/record MUST include ALL components present on the AHCCCS EPSDT Clinical Sample Template. If providers are utilizing hard copy EPSDT forms, make sure to use the correct age range form for the appropriate age of the member, on that date of service.

Providers can find the EPSDT Clinical Sample Template from the AHCCCS website at: **https://azahcccs.gov/shared/Downloads/MedicalPolicyManual/400/430_AttachmentE.docx**, under attachment E. The forms can also be found on the Mercy Care Website, under Provider Forms: **https://www.mercycareaz.org/providers/completecare-forproviders/forms**

Please refer to the **Claims Processing Manual, Chapter 3 – Early Periodic Screen and Developmental Testing (EPSDT)** on Mercy Care's website for specific claim codes.

Requirements for EPSDT providers

PCPs are required to comply with regulatory requirements and Mercy Care preventative requirements which include:

- Documenting immunizations within 30 days of administration into Arizona State Immunization Information System (ASIIS) and enroll every year in the Vaccine for Children Program.
- Providing all screening services according to the AHCCCS Periodicity Schedule and community standards of practice. The **AHCCCS EPSDT Periodicity Schedule** can be viewed by accessing the AHCCCS website.

- Ensuring all infants receive both the first and second newborn screening tests. Specimens for the second test may be drawn at the PCP's office and mailed directly to the Arizona State Laboratory, or the member may be referred to a Mercy Care contracted laboratory for the draw.
- Using the current AHCCCS EPSDT Clinical Sample Template or electronic health records to document all EPSDT well visit required screenings, treatments, and services provided and ensure they are in compliance with AHCCCS standards.
    - **Faxing the forms to Mercy Care is the preferred delivery method.**
      EPSDT Form Fax #: 602-431-7157
    - If mailing the forms, send to:
      Attn: Medical Management EPSDT Dept
      4500 E. Cotton Center Blvd., Phoenix, AZ 85040
- Using all clinical encounters to assess the need for EPSDT screening and/or services.
- Document in the medical record of the member's decision not to participate in the EPSDT program, if appropriate.
- Making referrals for diagnosis and treatment when necessary and initiate follow-up services within 60 days.
- Scheduling the next appointment at the time of the current office visit particularly for children 30 months of age and younger.
- Reporting all EPSDT encounters on required claims forms, using the Preventive Medicine Codes.
- Referring Mercy Care members (ACC and DD) to Children's Rehabilitative Services (CRS) when they have conditions covered by the CRS program.
- Referring members to community resources such as WIC, Raising Special Kids Home Visiting Programs, Early Head Start/Head Start, and the Birth to Five Helpline as appropriate.
- Refer and coordinate care with AzEIP to identify members from ages birth up to three years of age with developmental disabilities that are needing services, family education, and family support.
- Initiating and coordinating referrals to behavioral health providers as necessary.
- Discuss family planning services and supplies with any members that are of reproductive age or members that are sexually active.

An EPSDT screening includes the following basic elements:

- Comprehensive health and developmental history, including growth and development screening (includes physical, nutritional and behavioral health assessments).
- General Developmental screening (using an AHCCCS approved developmental screening tool) for members age 9, 18 and 30 months.
- Autism Specific developmental screening (using an AHCCCS approved developmental screening tool) for members age 18 and 24 months.
- Comprehensive unclothed physical examination.
- Appropriate immunizations according to age and health history.
- Laboratory tests appropriate to age and risk for the following: blood lead, tuberculosis skin testing, anemia testing and sickle cell trait.
- Health education and counseling about child development, healthy lifestyles and accident and disease prevention.
- Appropriate dental screening and referral.
- Fluoride varnish application every three months (by providers who have completed training) for members age 6-24 months with at least one tooth eruption.
- Appropriate vision and hearing/speech testing.
- Screening for age-appropriate weight gain. Use the BMI percentile for children 24 months and older.

- Anticipatory guidance should be provided so that parents or guardians know what to expect in terms of the child's development.
- Screening adolescents for suicide and depression starting at 10 years old.
- Screening the birthing mother for postpartum depression at the 1st, 2nd, 4th, and 6th EPSDT visit.

Periodic screenings

The AHCCCS EPSDT Periodicity Schedule specifies the screening services to be provided at each stage of the child's development. The AHCCCS EPSDT Periodicity Schedule (Policy 430, Attachment A) can be viewed on the AHCCCS website. This schedule follows the Center for Disease Control (CDC) recommendation.

Children may receive additional inter-periodic screening at the discretion of the provider. Mercy Care **does not limit** the number of well-child visits that members under age 21 may receive. Claims should be billed with the following CPT/ICD-9-CM Diagnosis (prior to 10/1/15) or ICD-10-CM Diagnosis (effective 10/1/15 and after) Codes based on age appropriateness:

Codes to identify Well-Child Visits – ages 0 months to 20 years of age

Well-Visit Ages **New Patients**	**CPT Codes**	**ICD-10 Codes**
Infant (Younger than 1 Year)	99381	Z00.110 Z00.111 Z00.121 Z00129
1-4 Years	99382	Z00.121 Z00.129
5-11 Years	99383	Z00.121 Z00.129
12-17 Years	99384	Z00.121 Z00.129
18 Years or Older	99385	Z00.00 Z00.01

Well-Visit Ages **Established Patients**	**CPT Codes**	**ICD-10 Codes**
Infant (Younger than 1 Year)	99391	Z00.110 Z00.111 Z00.121 Z00.129
1-4 Years	99392	Z00.121 Z00.129
5-11 Years	99393	Z00.121 Z00.129
12-17 Years	99394	Z00.121 Z00.129
18 Years or Older	99395	Z00.00 Z00.01

EPSDT visits (well-child visits) and sports physicals

Well-child visits for sports and other activities should be based on the most recent EPSDT well-child visit, as the annual well-child visits are comprehensive and should include all of the services required for sports or other activities. AHCCCS does not cover sports or other physicals solely for that purpose. If it can be combined with a regularly scheduled EPSDT visit, it is covered, though no additional payment would be allowable for completing the school or other organization paperwork that would allow the child to participate in the activity.

Oral health care (EPSDT age members)

As part of the physical examination, an oral health screening must be part of an EPSDT screening conducted by a physician, physician's assistant or nurse practitioner. The PCP must screen EPSDT members at each visit to identify those who require a dental referral for evaluation and treatment. A screening is intended to identify gross dental or oral lesions. However, it does not substitute for examination through a direct referral to a dentist. PCPs shall refer EPSDT members for appropriate services based on needs identified through the screening process and for routine dental care based on the AHCCCS EPSDT Periodicity Schedule. The physician may also 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. FFS members shall be referred to a dental provider by one year of age by their PCP and members enrolled with a Contractor shall be assigned to a Dental Home by six months of age. Evidence of this referral must be documented on the EPSDT Clinical Sample Template and in the member's medical record. In addition to physician referrals, EPSDT recipients are allowed self-referral to an AHCCCS registered dentist.

In addition to screening, members should make their first dental appointment by age one and every six months thereafter. This aligns with the AHCCCS Dental Periodicity schedule (**AMPM Policy 431, Attachment A**). Following the appointment availability schedules in **ACOM 417**, depending on the results of the oral health screening, referral to a dentist should be made according to the following timeframes:

Urgent- As expeditiously as the member's health condition requires but no later than three business days of request.
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.
Routine for DCS CHP- Within 30 calendar days of the request. If none of the above problems are identified.
The member's parent or guardian may also self-refer and schedule dental appointments for the member with any Mercy Care contracted general dentist. They may go directly to the dentist without seeing the PCP first and no authorization is required.

Dental Home

- American Association of Pediatric Dentistry (AAPD) encourages parents and other care providers to help every child establish a dental home by 6 months of age and includes referrals to dental specialists when appropriate.
- Mercy Care supports the American Association of Pediatric Dentistry (AAPD) recommendations and requires that all PCPs refer members to a dentist and encourage a dental home is assigned by 6 months of age.
- The AHCCCS Dental Periodicity schedule must be followed and recommends that members make their first dental appointment by age one and every six months thereafter.

Reduced Fee and Community Dental Clinics in Arizona

If a member loses AHCCCS eligibility, providers can redirect them to the available reduced fee and community dental clinic list provided by the Arizona Dental Association (AzDA) and Arizona Department of Health Services (ADHS). These dental providers often offer free or reduced dental care.

You can find the most up-to-date list on the ADHS website and here: **https://www.azdhs.gov/documents/prevention/womens-childrens-health/oral-health/reduced-fee-dental-clinics.pdf**

PCP application of fluoride varnish

Physicians who have completed the AHCCCS required training may be reimbursed for fluoride varnish applications completed at the EPSDT visit for recipients who are at least 6 months of age, and with at least 1 tooth eruption. Additional applications occurring every 3 months during an EPSDT visit, up until the recipient's 2nd birthday, will also be reimbursed.

AHCCCS recommended training for fluoride varnish application is located at the **Smiles For Life** website under Training Module 6 that covers caries risk assessment, fluoride varnish and counseling. Upon completion of the required training, providers should submit a copy of their certificate to CAQH. This certificate will be used in the credentialing process to verify completion of training necessary for reimbursement. The website for CAQH is **https://proview.caqh.org/Login/Index?ReturnUrl=%2f** and the phone number for CAQH is **888-599-1771**. Please use the following CPT code for billing this service: 99188-application of topical fluoride varnish by a physician or other qualified health care professional. Instructions on how to load documents into CAQH can be found under the developmental screening section of this manual on **page 12**.

This certification submission is also used in the credentialing process. Please refer to our **Claims Processing Manual**, Chapter 3 – Early and Periodic Screen and Developmental Testing (EPSDT), Section 3.3 – PCP Application of Fluoride Varnish for additional claims processing information.

Resources

ADHS Fluoride Varnish Training Resources: **https://www.azdhs.gov/prevention/womens-childrens-health/oral-health/index.php#programs-fluoride-varnish**

AHCCCS Dental Periodicity Schedule

AHCCCS MEDICAL POLICY MANUAL

POLICY 431 – ATTACHMENT A – AHCCCS DENTAL PERIODICITY SCHEDULE

RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC ORAL HEALTH CARE*				
These recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations may require modification for children with special health care needs.				
AGE	12-24 MONTHS*	2-6 YEARS	6-12 YEARS	12 YEARS AND OLDER
CLINICAL ORAL EXAMINATION INCLUDING BUT NOT LIMITED TO THE FOLLOWING:	X	X	X	X
➢ ASSESS ORAL GROWTH AND DEVELOPMENT	X	X	X	X
➢ CARIES-RISK ASSESSMENT	X	X	X	X
➢ ASSESSMENT FOR NEED FOR FLUORIDE SUPPLEMENTATION	X	X	X	X
➢ ANTICIPATORY GUIDANCE/COUNSELING	X	X	X	X
➢ ORAL HYGIENE COUNSELING	X	X	X	X
➢ DIETARY COUNSELING	X	X	X	X
➢ INJURY PREVENTION COUNSELING	X	X	X	X
➢ COUNSELING FOR NONNUTRITIVE HABITS	X	X	X	X
➢ SUBSTANCE USE COUNSELING			X	X
➢ COUNSELING FOR INTRAORAL/PERIORAL PIERCING			X	X
➢ ASSESSMENT FOR PIT AND FISSURE SEALANTS		X	X	X
RADIOGRAPHIC ASSESSMENT	X	X	X	X
PROPHYLAXIS AND TOPICAL FLUORIDE	X	X	X	X

* Those elements of the oral examination deemed appropriate by the provider may be performed as early as six months of age.

NOTE: Health Care Decision Makers (HCDM), and Designated Representatives (DR) should be included in all consultations and counseling of members regarding preventive oral health care and the clinical findings.

NOTE: As in all medical care, dental care must be based on the individual needs of the member and the professional judgement of the oral health provider.

* Adaptation from the American Academy of Pediatric Dentistry Schedule.

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Effective Dates: 10/01/18, 10/01/19, 02/01/21, 10/01/22
Approval Dates: 06/07/18, 05/30/19, 11/06/20, 04/21/22

Developmental Screening

All qualified medical professionals must provide proof of certification to the Council for Affordable Quality Healthcare (CAQH). The CAQH fax cover sheet should be used to send the required documentation of your completed training to CAQH. The website for CAQH is **https://proview.caqh.org/Login/Index?ReturnUrl=%2f** and the phone number for CAQH is **888-599-1771**. Upload certificate in CAQH under the *Education and Provider Training* tab. Instructions can be found in the **CAQH ProView Provider User Guide**. It is important to only upload 1 page/1 certificate at a time only. This will ensure successful upload to CAQH. We use the CAQH database to conduct random audits ensuring provider compliance with the AHCCCS training requirement. This certification submission is also used in the credentialing process. Certificates dated before August 1, 2014 will be accepted. A list of available training resources may be found in the Arizona Department of Health Services Website at **https://www.azdhs.gov/audiences/clinicians/index.php#training-developmental-screening-flouride-varnish**.

PCPs shall use AHCCCS approved tools. PCPs shall be trained in the use and scoring of the Developmental Screening tools, as indicated by the American Academy of Pediatrics. The general developmental screenings are mandatory during the 9 month, 18 month and 30 month EPSDT visits. The Autism Specific Developmental Screenings are mandatory during the 18 month and 24 month EPSDT visits.

Developmental screenings are part of the EPSDT services and are appropriate at any time they are indicated during the EPSDT period. Developmental surveillance should be part of every EPSDT visit, and if concerns are noted, further screenings would be indicated.

- **Ages and Stages Questionnaires™ Third Edition (ASQ)** is a tool which is used to identify developmental delays in the first 5 years of a child's life. The sooner a delay or disability is identified, the sooner a child can be connected with services and support that make a real difference **www.agesandstages.com**. Age range: Birth to 5 years of age.
- **Ages and Stages Questionnaires®: Social-Emotional (ASQ:SE)** is a tool which is used to identify developmental delays for social-emotional screening. Age Range: up through 21 years old.
- **Modified Checklist for Autism in Toddlers (M-CHAT)** may be used only as a screening tool by a primary care provider, for members 15-30 months of age, to screen for autism when medically indicated **www.firstsigns.org**. Age range: 15 to 30 months.
- **The Parents' Evaluation of Developmental Status (PEDS)** may be used for developmental screening of EPSDT-aged members **www.pedstest.com** or **https://pedstestonline.com/**. Age range: Birth to 8 years of age.
- Providers may bill for this service as long as the following criteria is met:
  - The member's EPSDT visit is at either 9, 18, 24, or 30 months;
  - Prior to providing the service, the provider is required to complete the required training for the AHCCCS-approved developmental screening tool being utilized and submit a copy of the training certificate to CAQH.
  - The code is appropriately billed (96110-EP). Copies of the completed tools must be retained in the medical record.
  - Developmental screenings (using AHCCCS-approved tools) can be billed separately with an EP modifier at the 9, 18, 24, and 30-month visit.
  - For these EPSDT visits only, the 96110-EP code can be used twice in the same visit when clinical circumstances warrant more than one tool to be used during the visit.

Developmental Screening Resources

You can find multiple documents, flyers, and pamphlets that can be printed out. They can be used by your office, or they can be handed to members.

The CDC has useful information:

- CDC Child Development: Developmental Screening website
- Brief Checklist of Milestones
- Developmental Monitoring and Screening Fact Sheet

Additional websites/resources that can be helpful and educational:

- Bright Futures: This Site Has a List of Available Screening Tools
- Birth to 5: Watch Me Thrive! – This Site Has a List of Available Screening Tools
- "Learn the Signs. Act Early."
- Overview of Early Intervention

ASQ Training Resources: https://agesandstages.com/

AAP Screening Tool Finder: https://www.aap.org/en/patient-care/screening-technical-assistance-and-resource-center/screening-tool-finder/

Autism Spectrum Disorder Resources

These are some helpful websites with resources created to help parents/guardians that have children with Special Needs and Developmental Disabilities

- http://phxautism.org
- http://www.azautism.org/
- https://www.azahcccs.gov/shared/asd.html
- https://www.autismcenter.org/
- https://www.healthychildren.org/
- http://www.raisingspecialkids.org/
- http://www.familyvoices.org/

EPSDT Visits and BMI

Body Mass Index (BMI) is used to assess underweight, overweight, and at risk for becoming overweight. Children's body fatness changes over the years as they grow. Also, girls and boys differ in their body fatness as they mature. For children it is referred to as BMI for age. This is because it is gender and age specific. BMI for age is plotted on gender specific growth charts for children and teens 2-20 years of age. Percentiles are the most commonly used clinical indicator to assess the size and growth patterns of individual children in the United States. Percentiles rank the position of an individual by indicating what percent of the reference population the individual would equal or exceed.

PCPs are required to calculate the child's BMI and percentile beginning at age 24 months until the member is 21 years old. While it is still appropriate for PCPs to evaluate growth prior to age 2; it is important that PCPs follow CDC recommendations, utilize the World Health Organization's growth charts, and ensure that the assessment takes into consideration both the child's age and gender in determining the assessment of growth.

Percentile cutoff points	
Underweight	BMI for age < 5th percentile
Healthy weight	BMI for age 5th percentile to < 85th percentile
Overweight	BMI for age 85th percentile to < 95th percentile
Obese	BMI for age >=95th percentile

If a child is determined to be below the 5th percentile, or above the 85th percentile, the PCP should have a discussion with the member's parent/guardian about:

- **Diet, exercise, and the importance of living a healthy lifestyle.**
- **Referrals to a dietician or nutritionist, if necessary.**
- **The growth and development issues that may arise when a person is underweight or overweight.**

Appropriate Weight Gain and Nutrition Resources

Websites/Documents/Resources that can be helpful and educational:

- Growth Chart Information: **https://www.cdc.gov/growthcharts/index.htm**
- WHO Growth Chart – Ages 0-2yo: **https://www.cdc.gov/growthcharts/who_charts.htm**
- CDC Growth Chart – Ages 2yo and older: **https://www.cdc.gov/growthcharts/cdc_charts.htm**
- Educational Materials: **https://www.cdc.gov/growthcharts/educational_materials.htm**
- WIC Program: **https://www.azdhs.gov/prevention/azwic/**
- National WIC Website: **ChooseMyPlate.gov**
- National WIC Website: **Nutrition.gov**
- Family & Children Information: **AZ Health Zone**
- Family & Children Information: **Arizona Resource Guide for Supporting Children with Life-Threatening Food Allergies**
- Family & Children Information: **HealthyChildren.org**
- Family & Children Information: **Healthy Eating and Physical Activity**
- Family & Children Information: **KidsHealth.org**
- American Academy of Pediatrics: **Clinical Practice Guideline for Obesity**

Additional resources available for your review regarding the prevention of childhood obesity include:

- **AAP Institute for Healthy Childhood Weight**
  https://ihcw.aap.org/Pages/default.aspx
- **AAP Clinical Report: The Role of the Pediatrician in Primary Prevention of Obesity**
  https://pediatrics.aappublications.org/content/136/1/e275
- **ADHS**
  https://www.azdhs.gov/prevention/nutrition-physical-activity/index.php
- **CDC BMI Assessment**
  http://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html

Nutritional assessment and nutritional therapy

Mercy Care covers nutritional assessment and nutritional therapy for EPSDT 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 following requirements apply:

- Nutrition and the member's weight must be assessed at each visit.
- Providers must attempt to identify any possible causes of the members growth and development issues and document this in the members medical records. If the issues cause the member to be underweight or overweight, then the provider must address these concerns with the member/caregiver.
- Members in need of nutritional therapy should be identified and referred to a registered dietician in Mercy Care's network.
- Members in need of nutritional supplements may be referred to Aveanna Healthcare; Mercy Care's contracted DME provider for these services.
- Nutritional therapy requires prior authorization and approval by Mercy Care. In order to determine prior authorization, Mercy Care requires the **AHCCCS Policy 430, Attachment B, Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (EPSDT Aged Members – Initial or Ongoing Requests)** form, along with clinical notes, supporting documentation and evidence of required criteria as indicated in the Certificate of Medical Necessity to be sent to Aveanna Healthcare. Their fax number is **844-754-1345**. Aveanna Healthcare will contact Mercy Care to request prior authorization.
- Supporting documentation must accompany the Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (Members 21 years of age or under- Initial or Ongoing Requests). This documentation must demonstrate that the member meets all of the required criteria and meets medical necessity on an individual basis.

For detailed information regarding Nutritional Assessment and Nutritional Therapy, please refer to the **AHCCCS Medical Policy Manual (AMPM), Chapter 400 – Medical Policy for Maternal and Child Health**.

Certificate of Medical Necessity

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:

At least two of the following criteria have been met for the basis of establishing medical necessity:

(a) The member 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.**

(b) The member has 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**.

(c) The member has already demonstrated a medically significant decline in weight within the **three month period** prior to the assessment.

(d) The member is able to 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, etc.), and

(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 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 AHCCCS Policy 430, Attachment B, Certificate of Medical Necessity for Commercial Oral Nutritional Supplements along with supporting documentation demonstrating the risk posed to the member for the Contractor's Medical Director or Designee's consideration in approving the provider's prior authorization request.

Aveanna Healthcare is Mercy Care's vendor for all nutritional supplements.
Please forward the AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements directly to them at:

Phone: **480-883-1188**
Toll free: **1-866-883-1188**
Fax: **844-754-1345**

Metabolic medical foods

Children who have been diagnosed with the following genetic metabolic conditions and who need metabolic medical foods may receive services through their genetics provider. Mercy Care covers medical foods, within the limitations specified in the **AHCCCS Medical Policy Manual, (AMPM), Chapter 300 - 310 GG Nutritional Therapy, Metabolic Foods, and Total Parenteral Nutrition** for any member diagnosed with any of the following inherited 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)
- Long Chain acyl-CoA dehydrogenase deficiency (LCHAD)

Other screenings

Eye Examinations and Prescriptive Lenses

EPSDT includes eye exams and prescriptive lenses to correct or ameliorate defects, physical illness and conditions. PCPs are required to perform basic eye exams and refer members to the contracted vision provider for further assessment. This includes unlimited replacement and repair of eyeglasses, when medically necessary for vision correction, for members under 21 years of age. This includes but is not limited to, loss, breakage, or change in refraction. To receive eyeglass replacement or repair, EPSDT members do not need to wait for their next scheduled EPSDT well child visit. Ocular photo screening with interpretation and report, bilateral (CPT code 99177) is covered for children ages three to six as part of the EPSDT visit due to challenges with a child's ability to cooperate with traditional chart-based vision screening techniques. Ocular photo screening is limited to a lifetime coverage limit of one.

Hearing/Speech Screening

Hearing evaluation consists of appropriate hearing screens given according to the EPSDT schedule. Evaluation consists of history, risk factors, parental questions and impedance testing.

- Pure-tone testing should be performed when medically necessary.
- Speech screening shall be performed to assess the language development of the member at each EPSDT visit. Effective June 1, 2017, hearing screenings and follow-up services for babies born in 2017 will be handled by The EAR Foundation of AZ. Please contact the Office of Newborn Screening at **nbseducation@azdhs.gov** 602-364-1409 or outside Phoenix metro (800) 548-8381. Fax: (602) 364-1495, or The EAR Foundation of Arizona at **ehdi@earfoundationaz.com** (602) 904-6344 with questions.

TB monitoring & testing requirements

- Tuberculin skin testing should be performed as appropriate to age and risk. Children at increased risk of tuberculosis (TB) include those who have contact with persons:
  - Confirmed or suspected of TB.
  - In jail during the last five years.
  - Living in a household with an HIV-infected person or the child is infected with HIV.
  - Traveling/emigrating from, or having significant contact with persons indigenous to, endemic countries.

Blood Lead Screening and Testing

Lead poisoning continues to affect children in Arizona, primarily from paint, imported goods, food, medicines, spices, lead in dust, soil, mining, drinking water, and occupation and hobbies.

- **All children 6 months to 6 years old** are recommended to have a **verbal lead screening** completed at each EPSDT visit. Those screening results should help identify members who are at an increased risk for blood lead poisoning and in need of a **blood lead test**.
- All children ages **12 and 24 months of age** must have a **blood lead test**.
- Children between the ages of **24 months and 72 months of age** who have not been previously tested, or who missed either the **12 month or 24 month test,** must have a **blood lead test**.
- In accordance with the AHCCCS Medical Policy Manual (AMPM), additional testing for children **less than 6 years of age** is based on the child's risk as determined by either the residential zip code or presence of other know risk-factors.

Recommended Blood Lead Testing Schedule

The CDC uses a blood lead reference value (BLRV) of **3.5 micrograms per deciliter (µg/dL)** to identify children with blood lead levels that are higher than most children's levels. There are 2 types of tests given:

- A finger-prick or heel-prick (capillary) sample- This is usually the first step to determine if a child has lead in their blood.
- A venous blood draw – This is usually done to confirm the blood lead level seen in a previous test. The table below shows when a child with lead in their blood should receive a venous blood draw to confirm their blood lead level.

Recommended Schedule for Obtaining a Confirmatory Venous Sample

Capillary Blood Lead Level (µg/dL)	Time to Confirmation Testing
≥ 3.5-9	Within 3 months
10-19	Within 1 month
20-44	Within 2 weeks
≥ 45	Within 48 hours

Blood Lead Level Testing Resources

The CDC has useful information:

- Blood Lead Levels in Children
- Blood Lead Reference Value
- Recommended Actions Based on Blood Lead Level
- CDC's Recommended Terminology When Discussing Children's Blood Lead Levels
- Recommendations of the Advisory Committee for Childhood Lead Poisoning Prevention (ACCLPP) "Low Level Lead Exposure Harms Children: A Renewed Call of Primary Prevention"
- HRSA-CDC Letter on Childhood Lead Poisoning Prevention and Blood Lead Testing [PDF – 213 KB]

CDC Fact Sheets

- 5 Things You Can Do [PDF – 234 KB] en Español [PDF – 166 KB]
- All Children Can Be Exposed to Lead (Printable PDF [PDF – 1 MB])
- Blood Lead Levels in Children [PDF – 100 KB]

Additional resources from ADHS that can be helpful and educational:

- ADHS: Risk Assessment Parent Questionnaire
- ADHS: List of High-Risk Zip Codes
- ADHS: Find My Zip Code on a Map

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 visit is a separately billable service if:
  - An abnormality is encountered or a preexisting problem is addressed in the process of performing an EPSDT service and the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service.
  - The “sick visit” is documented on a separate note.
  - 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).
  - 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.***

AzEIP

The Arizona Early Intervention Program (AzEIP) is an early intervention program that offers a statewide system of support and services for children birth through three years of age and their families who have disabilities or developmental delays. This program was jointly developed and implemented by AHCCCS and the Arizona Early Intervention Program (AzEIP) to ensure the coordination and provision of EPSDT and early intervention services. Such services include physical therapy, occupational therapy, speech/language therapy, nutrition therapy and care coordination under Sec. 1905 [42 U.S.C 1396d]. Concerns about a child’s development may be initially identified by the child’s Primary Care Provider or by AzEIP. Mercy Care coordinates with AzEIP to ensure that members receive medically necessary EPSDT services in a timely manner to promote optimum child health and development. For additional information, please contact the Mercy Care AzEIP Coordinator.

AzEIP Coordination of Care Process

AHCCCS and AzEIP jointly developed this process to ensure the coordination and provision of EPSDT and early intervention services. This process describes procedures taken by the child’s Primary Care Provider, and by AzEIP, when concerns about a child’s development are initially identified. The care coordination also involves care management and parents/guardians, when appropriate. We have outlined the AzEIP Coordination process to help ensure the process is completed accurately and within a timely manner. **Please follow the timelines outlined in AMPM 430-Attachment C.**

AzEIP Initiated Service Requests

- AzEIP receives a referral for a member and the AzEIP Support Coordinator reviews the request and if approved, they complete an Individual Family Service Plan (IFSP).
- Once the IFSP is complete, they send all IFSP documents, including the AHCCCS Member Service Request form (AMPM 430-Attachment D) and all evaluations/developmental summaries to the MC AzEIP Coordinator for review.
- The MC AzEIP Coordinator begins the coordination process with the PCP to get the member their medically necessary EPSDT services.

- MC AzEIP Coordinator will research in the system to see if the member has ALTCS, DCS CHP, or if they currently have a case manager. If they do, then the MC AzEIP Coordinator will involve case management to help coordinate care.
- The MC AzEIP Coordinator will fax the member's PCP a service request referral form and all documentation included in the IFSP. The PCP will review the documentation and determine which services are medically necessary.
- The PCP will fax back the completed referral form to the MC AzEIP Coordinator. The referral form must include a signature, date, and check mark indicating if services requested are medically necessary.
  - If the PCP needs to see the child before determining the child's need for services, the appointment will be scheduled as a routine appointment.
  - If the PCP needs more time, they can request an extension. The extensions should not exceed 10 working days. The PCP will then return the referral request form and indicate the status by noting that an appointment has been scheduled, as well as the appointment date.
- Once the MC AzEIP Coordinator receives the completed referral form from the PCP, they will create a prior authorization (PA) for the requested services.
- The PA is reviewed, and a decision is made to either approve or deny the request.
- The MC AzEIP Coordinator then sends the decision (approved or denied) to the AzEIP Service Coordinator and the service facility. The Notice of Action (NOA) team sends the final decision (approved or denied) to the PCP. If denied, the MC AzEIP Coordinator will perform a few extra steps to help with coordination of care. (Please see the denial process below.)

AzEIP PCP Initiated Service Requests

- During the EPSDT visit the PCP will determine the child's developmental status through discussion with the family/parents/guardian and developmental screening.
- During that same EPSDT well-child visit, the PCP must also complete the EPSDT form (or the submitted the electronic health record), and the AzEIP referral must be noted. Mentioning the AzEIP referral is important as it is used for reporting, and it also triggers a letter to the member informing them about the program. Submitting the EPSDT form in a timely manner helps to avoid any delay care for the member.
- When the PCP identifies potential developmental delays and the services are determined to be medically necessary, the PCP will request an evaluation by a specialist in the field that the delay and the PCP will submit a prior authorization (PA) request to Mercy Care.
- The PA is reviewed, and a decision is made to either approve or deny the request.
- The MC AzEIP Coordinator then sends the final PA decision (approved or denied) and the to the AzEIP Service Coordinator and the service facility. The Notice of Action (NOA) team sends the final decision (approved or denied) to the PCP. If denied, the MC AzEIP Coordinator will perform a few extra steps to help with coordination of care. (Please see the denial process below.)
- The PCP should also be referring the member to AzEIP for support and education via the online AzEIP portal: **https://azeip.azdes.gov/AzEIP/AzeipRef/Forms/Categories.aspx**.
- Once the provider has sent in the completed EPSDT well-visit Clinical Sample form (or electronic health record) and it has been received by Mercy Care, the MC AzEIP coordinator is notified.
- MC AzEIP Coordinator will research in the system to see if the member has ALTCS, DCS CHP, or if the member currently has a case manager. If they do, then the MC AzEIP Coordinator will involve case management to help coordinate care.

- The MC AzEIP coordinator then emails the AzEIP referral line to verify if the member is enrolled in AzEIP. Email: **AzEIP.Info@raisingspecialkids.org**
  - If the enrollment process has not begun, then the Mercy Care AzEIP coordinator will reach out to the PCP to ensure that they begin the enrollment process.
- All documentation is then sent to the AzEIP Service Coordinator for review.
  - If they approve the member to be enrolled, then they will send the documentation to the MC AzEIP Coordinator for review.
- MC AzEIP Coordinator will send the PCP a service request referral form and all other documentation to review and determine which service requests are medically necessary.
- PCP will return the completed service request referral form to the MC AzEIP Coordinator. The referral form must include a signature, the date, and a check mark indicating if services requested are medically necessary.

AzEIP Coordination Process: Member is not AzEIP Eligible or the PA is Denied

- If the AzEIP prior authorization (PA) is denied, then the MC AzEIP Coordinator must perform these steps in additional to the process listed above in order to coordinate care for the child:
  - If the PA is denied, they will contact the medical director to provide any additional information needed to help get the authorization approved.
  - They will verify if the member has ALTCS, DCS CHP, or if they currently have a care manager. If they do, then the care manager will be informed of the denial, so they can also coordinate care.
  - If unsuccessful, they will send the AzEIP Service Coordinator and the service facility a copy of the denial, the AHCCCS Member Service Request form (AMPM 430-Attachment D), and all other documentation used to make the decision.
  - They will then contact the parents/guardians to assist them in finding a therapist to help their child receive care and make an appointment and document the call notes in our PA system. (Currently, no PA is needed for these non-AzEIP visits.)
- If the member is not AzEIP eligible, then the MC AzEIP Coordinator must perform these steps in additional to the process listed above in order to coordinate care for the child:
  - They will discuss the ineligible decision with the PCP and advise them to speak with the members parent/guardian about their next steps.
  - They will verify if the member has ALTCS, DCS CHP, or if they currently have a case manager. If they do, then the case manager will be informed, so they can help the member coordinate care. They will then contact the parents/guardians to assist them in finding a therapist to help their child receive care and make an appointment and document the call notes in our PA system. (Currently, no PA is needed for these non-AzEIP visits.)

Questions about timelines or the AzEIP process, you can find it on the AHCCCS website or on the DES website:

- **AMPM Policy 430 – Attachment C: AzEIP Procedures and Coordination**
- **AMPM Policy 430 – Attachment D: AzEIP Member Service Request Form**
- **https://des.az.gov/azeip**

You can also contact AzEIP through their referral phone line at **602-532-9960** or **1-888-592-0140** or you can email the AzEIP Referral Department at **AzEIP.Info@raisingspecialkids.org**.

Additional AzEIP Resources

Pamphlets and Flyers

You can find multiple flyers and pamphlets that can be printed out and handed to members. You can find them on the DES website, in the document center, under **Flyers and Pamphlets**.

Early Childhood Programs

- **Arizona State Schools for the Deaf and the Blind**
- **AZ Find Info for Families, ADE**
- **Early Childhood Special Education, ADE**
- **First Things First, Home Visiting Program Locator**
- **Early Head Start and Head Start**
- **Strong Families Arizona, Home Visiting Program Locator**

Parent Support, Training, and Information Centers

- **Raising Special Kids**
- **Pilot Parents of Southern Arizona (Pima, La Paz, Yuma, Gila, Pinal, Cochise, Gila, Graham, Greenlee, and Santa Cruz counties)**
- **Center for Parent Information and Resources**

Successful strategies: Reducing missed appointments

A number of studies suggest that the cultural norms or social circumstances of families may have an effect on the rate of missed appointments. Living in a deprived area has been associated with a threefold increase in the likelihood of missing an appointment. Some of the most common reasons include: lack of transportation, scheduling problems, overslept or forgot, presence of a sick child or relative, and lack of child-care. Highlighted below are current best practice interventions that may help you and your office decrease missed appointments.

Patient contact

- Thank patients for keeping their appointments and arriving on time.
- Ask patients how they want to be reminded of their appointment and provide options for cell phone and home phone.
- Perform automated telephone appointment reminder calls.
- Make the reminder call at least 48 hours prior to the appointment.
- Contact patients who miss appointments and reschedule them promptly.
- Engage the patient in the relationship with the practice by making statements such as:
  - "Dr. Jones was very disappointed that you didn't show up for your appointment."
  - "I'll let Dr. Jones know that you wish to reschedule. When shall I tell him that you would like to reschedule?"
- Send correspondence about no-shows directly from the physician.
- Educate patients who have chronic conditions that their status and medications need to be monitored with regular office appointments, even if they feel fine.

Other practices

- Document history of patients' no-shows and identify "frequent no-show" in your practice management system alert messaging.
- Develop a protocol for how cancelled appointments will be rescheduled for other patients.

- Ease patients' ability to notify you of a cancellation by offering 24/7 cancellation line with voicemail.
- Establish a waitlist for patients who want earlier appointments for rescheduling.
- Document disconnected phone numbers in the practice management system.
- Hold a team conference before every clinic and prioritize a review of the schedule for today. Cancel patients who have been admitted to the hospital.
- Confirm that you have cancelled previously scheduled appointments in the practice management system when a patient calls for an acute appointment request.

Mercy Care will help
To help reduce missed appointments, Mercy Care has implemented several ongoing interventions:

- For every member who schedules an appointment through our outreach staff, an appointment reminder card is mailed to him/her listing the date and time of the appointment.
- If the patient misses an appointment, notify the Mercy Care EPSDT and MCH Department and our outreach staff will contact the member by letter and phone to assist him/her in making another appointment. During the phone call, the member will also receive education on the importance of showing up for scheduled appointments. If the member has ALTCS, DCS CHP, ACC-RBHA, or if they currently have a care manager, then the Mercy EPSDT and MCH Dept outreach staff may not be the ones to reach out to the member. The may receive the outreach from their care manager instead.
  - A couple examples of ways a provider can notify the plan, is through submitting an EPSDT form or a completed Missed Appointment Log. Both of these can be found on the **Mercy Care Provider website - under Provider Forms**.

Behavioral Health Screenings, Referrals and Follow up Requirements

PCPs are allowed to treat behavioral health conditions that are within their scope of practice. When the behavioral health condition is outside of their scope, the PCP is required to provide coordination for the member with a behavioral health provider. Coordination may include a referral and/or transition of care to a behavioral health provider. Coordinate of care for behavioral health services must be completed in a timely manner.

Behavioral health care coordination is needed for the following:

- The member presents with a behavioral health diagnosis outside of the PCP's scope of practice. Examples of disorders that a PCP can treat: ADHD, depression, anxiety, postpartum depression, substance use disorder, or opioid use disorder (MAT services).
- The member has been admitted to an inpatient hospital for a behavioral health diagnosis.
- The member does not respond to treatment and therefore need additional behavioral health services, such as counseling and/or more intense medication monitoring.
- The member has experienced a sentinel event, such as an attempted suicide, they are a danger to themselves, or they are a danger to others.
- The member requires services outside the PCP's scope of expertise.

AHCCCS also provides tools to help Navigate the Behavioral Health System. You can find them here:
https://www.azahcccs.gov/OIFATools

PCP Responsibilities:

- Call MC member services to find a behavioral health provider for the member.
- Identify an appropriate behavioral health provider for the member. The decision should be based on finding an "in network" provider, consider the member's clinical presentation, their referred locations, and their cultural preferences.
  - If necessary, MC member services can assist the member with scheduling an intake appointment with the identified BH provider.
- Collect basic information about the member to determine the urgency of the situation and assist with the subsequent scheduling of intake session. This must be done within the required timeframes and with an appropriate provider.
- Keep the members behavioral health information and documents confidential and protected in accordance with applicable federal and state statutes, regulations, and policies.
- Inform the referred organization if there are any changes to the referral, such as refusing services, change in need, etc.).
- Inform the behavioral health providers, if known, when a member's health status changes, their medication changes, or any new medications have been prescribed.

Regional Behavioral Health Authorities (RBHAs) Referrals

Mercy Care ACC-RBHA plan covers the Central GSA in the following counties:

- Maricopa County
- Pinal County
- Gila County

Don't Delay… Act on a referral regardless of how much information you have. The **Mercy Care ACC-RBHA Provider Manual** lists out information that can be very helpful when making a referral. While the information listed in the manual is helpful and is useful when trying to evaluate the urgency and type of practitioner the member may need to see, timely triage and processing of referrals must not be delayed because of missing or incomplete information.

Providers can fax in a referral using any written format, or they can call:

Mercy Care ACC-RBHA Member Services at 800-564-5465
Mercy Care ACC-RBHA Referral Fax # 844-424-3975

Mercy ACC-RBHA Crisis Intervention and NurseLine Services - available 24/7:

- Phone Line 602-222-9444
- Toll free 800-631-1314
- Toll Free TTY 800-327-9254

AHCCCS Suicide and Crisis Hotlines by County and Tribal Nation
https://www.azahcccs.gov/BehavioralHealth/crisis.html

AHCCCS Navigating the BHS System

DOES THE INDIVIDUAL APPEAR TO BE AN IMMEDIATE DANGER TO HIS/HER OWN SAFETY OR TO THE SAFETY OF OTHERS?

CALL 911

DOES THE INDIVIDUAL APPEAR TO BE IN NEED OF MENTAL HEALTH ASSISTANCE RIGHT AWAY?

CALL 988 OR 1-844-534-HOPE OR FIND MORE RESOURCES ON THE CRISIS SERVICES WEB PAGE

Accessing/Paying for Behavioral Health

To enroll in the health insurance marketplace, visit www.healthcare.gov

START HERE
Does the person have commercial health insurance or Medicare?
- YES: Contact the health insurance company to get a referral for behavioral health services. Medicare pays 80% of initial visit to behavioral health professionals and 55% of follow- up visits. Locate providers at medicareinteractive.org.
- NO ↓

To enroll with AHCCCS, visit healthearizonaplus.gov

Does the person have Medicaid (AHCCCS) health insurance?
- YES: Contact the AHCCCS Complete Care Plan or ACC-RBHA in their region of the state (See page 2, section A).
- NO ↓

Is this person a K-12 student?
- YES: Contact their educational institution to get a referral to obtain behavioral health services for uninsured students.*
- NO ↓

Does the person have a substance use disorder?
- YES: Contact the AHCCCS Complete Care Plan or ACC-RBHA or in their region of the state. (See page 2-Section A).
- NO ↓

Has this person ever served in the military?
- YES: Contact the Veterans Administration (VA) in their region of the state to determine whether the veteran will qualify for VA-funded services. (See page 2-Section B)
- NO ↓

Is the person a member of a federally recognized tribal nation?
- YES: Contact Indian Health Services (IHS) to determine eligibility and receive referral information:
  - Navajo Nation: 928-871-4811; serving Navajo Nation.
  - Tucson: 520-295-2405; serving the Tohono O'Odham Nation and Pascua Yaqui tribe.
  - Phoenix: 602-364-5039; Alcohol and Substance Abuse: 602-364-5159; Suicide Issues: 602-364-5183; serving all other Arizona tribal nations.
- NO: (See page 2, section C)

*Senate Bill 1523 established the Children's Behavioral Health Services Fund (CBHSF) in 2020 to assist with increased access for behavioral health services. Written parental consent for behavioral health services will be requested.

BHS System Resources - Section A

SECTION A

Tribal Regional Behavioral Health Authorities (TRBHAs), AHCCCS Complete Care Regional Behavioral Health Agreements (ACC-RBHAs) and AHCCCS Complete Care Plans By Region

Note: latest website and 24-hr line information is posted on the Available Health Plans web page.

TRBHAs and ACC-RBHAs	County or Tribal Nation Served
Arizona Complete Health-Complete Care Plan ACC-RBHA www.azcompletehealth.com/completecare, 1-888-788-4408	La Paz, Pima, Yuma, Graham, Greenlee, Santa Cruz, and Cochise
Gila River TRBHA: www.grhc.org/bhs, 1-888-484-8526 ext. 7100	Gila River Indian Community
Mercy Care ACC-RBHA: www.mercycareaz.org, 1-800-624-3879	Gila, Maricopa, Pinal
Navajo Nation TRBHA: www.nndbmhs.org, 1-866-841-0277	Navajo Nation
Care1st ACC-RBHA: www.care1staz.com, 1-866-560-4042	Apache, Coconino, Mohave, Navajo, Yavapai
Pascua-Yaqui TRBHA: www.pascuayaqui-nsn.gov/index.php/centered-spirit, 520-879-6060	Pascua Yaqui Tribe
White Mountain Apache TRBHA: www.wmabhs.org, 928-338-4811	White Mountain Apache Nation
ACC Plan	**Geographic Service Area (GSA) Served**
Care1st Health Plan: www.care1staz.com, 1-866-560-4042	North, Central
Health Choice Arizona: www.HealthChoiceAZ.com, 1-800-322-8670	North, Central
Molina Complete Care: www.MolinaHealthcare.com, 1-800-424-5891	Central
Mercy Care: www.mercycareaz.org, 1-800-624-3879	Central
Banner-University Family Care: www.bannerufc.com/acc, 1-800-582-8686	Central, South
UnitedHealthcare Community Plan: www.uhccommunityplan.com, 1-800-348-4058	Central, Pima County
Arizona Complete Health-Complete Care Plan: www.azcompletehealth.com/completecare, 1-888-788-4408	Central, South

SECTION B

Veterans Administration (VA) by Region

VA Health Care System	Counties Served
Phoenix: 602-277-5551	Gila, Maricopa
Northern Arizona: 928-445-4860	Apache, Coconino, Mojave, Navajo, Yavapai
Southern Arizona: 520-792-1450	Cochise, Graham, Gila, Greenlee, La Paz, Pima, Pinal, Santa Cruz, Yuma

SECTION C

Additional Resources

Some free or low-cost support services may be obtained from sliding fee scale clinics, community organizations, and/or places of worship. Some examples include:

The Arizona Department of Financial Institutions: offer free counseling service to those behind on mortgage payments or facing foreclosure, 877-448-1211. SOS Non Title 19 Resource Hotline: (602) 759-8175.

Transitional Living Centers "TLC": Helping recovering substance abusers rebuild their lives since 1992 www.transitionalliving.org.

Family Involvement Center "FIC": Select "Services" then "Classes/Support Groups" www.familyinvolvementcenter.org.

NAMI AZ: Select your local affiliate and select "Support Groups" www.namiarizona.org.

MIKID AZ: Select "Programs and Services" and select "Family Support" www.mikid.org/.

Stand Together and Recover (STAR) Centers: Peer Support and Recovery Centers: www.thestarcenters.org.

Substance Use Support:

- National Drug and Alcohol Referral Routing Service: 1-800-662-HELP (4357), press "2" for Spanish or: findtreatment.samhsa.gov.
- Alcoholics Anonymous (AA) meeting locator: www.area03.org/AA-Meetings.
- Narcotics Anonymous (NA): 1-818-773-9999; online arizona-na.org.

Suicide Prevention Resources:

- National Suicide Prevention Lifeline: 988, press "1" for veteran support; online www.suicidepreventionlifeline.org
- National Suicide Prevention Lifeline in Spanish: 1-888-628-9454.
- The Trevor Hotline (Suicide Prevention Hotline for gay and questioning youth): 1-866-488-7386; online www.thetrevorproject.org
- Teen Lifeline: 1-800-248-TEEN (8336); online teenlifeline.org.
- Low cost/no cost support groups: www.mentalhealthamerica.net/find-support-groups.

Rev 11/1/2022

Adolescent Suicide and Depression Screening

Arizona has created The Arizona Suicide Prevention Action Plan to help reduce the rates of suicide in the state of Arizona. Suicide is a serious public health problem that can have lasting harmful effects on individuals, families, and communities. In 2020, suicide was the 10th leading cause of death in Arizona, with 1,363 certified deaths attributed to suicide among its residents. Arizona's rate of suicide per 100,000 of population was 35% higher than that of the U.S. in 2020. Suicide has continued to remain a major threat to public health over the last decade.

Providers must perform the AHCCCS required Adolescent Suicide and Depression screening for all individuals at each of their EPSDT visits from age 10-20 years old. Providers must use a standardized, norm-referenced screening tool specific for suicide and depression and the tool must be saved to the member's medical record. Positive results must be referred in a timely manner to an appropriate behavioral health provider for further evaluation and services.

This requirement is outlined in AMPM 430 EPSDT Policy and in the **AMPM 430-Attachment A: EPSDT Periodicity Schedule**.

Suicide Prevention Resources

You can find information, pamphlets, and display posters that can be printed out and handed to members. You can find them on the ADHS website, CDC Website, and more. Use the links below:

- **ADHS Suicide Prevention**
- **Arizona Suicide Prevention Plan**
- **CDC Suicide Prevention Resources**
- **Lifeline** (provides, free and confidential support 24/7)

Suicide Prevention Hotlines

- **National Suicide Prevention Lifeline:** 988
- **Arizona State Crisis Line:** 1-844-534-HOPE (4673) (English/Español)

Postpartum Depression Screening of the Birthing Mother

Maternal mental health conditions can appear during pregnancy and the first 12 months after childbirth. They can occur in parents of every age, race, culture, and income level. There are a spectrum of conditions that are referred to as perinatal and postpartum mood and anxiety disorders. They include, pregnancy and postpartum anxiety, pregnancy and postpartum obsessive-compulsive disorder, postpartum post-traumatic stress disorder, postpartum psychosis, and the most common condition being "pregnancy and postpartum depression".

Providers must perform the AHCCCS required Postpartum Depression screening for the birth parent at the 1 month, 2 month, 4 month, and 6 month EPSDT visits. Providers must use a standardized, norm-referenced screening tool specifically looking for postpartum depression and the tool must be saved to the member's medical record. Positive results must be referred in a timely manner to appropriate case managers and services at the respective birthing mother's health plan.

Postpartum Depression Educational Resources

- **ADHS Maternal Mental Health Prevention**
- **ADHS Display Posters**
- **Maternal Mental Health Leadership Alliance Fact Sheet**

National organizations and resources for postpartum depression

- **Postpartum Support International (PSI):** Information, education, and support for parents, support systems, and professionals.
- **CDC HEAR HER Campaign:** Information about Urgent Maternal Warning Signs, including maternal mental health.
- **Maternal Health Learning and Innovation Center:** Maternal health resources and education.
- **2020 MOM:** Maternal mental health information and advocacy.
- **Maternal Mental Health Leadership Alliance:** Information on maternal mental health conditions and advocacy to improve mental health care for mothers and childbearing people.

Mental Health Hotlines

- **Maternal Mental Health Hotline:** 1-833-9 HELP4MOMS (1-833-943-5746)
- **Suicide Prevention and Crisis Line:** 988
- **Postpartum Support International Warmline:** 1-800-944-4773

Psychiatric and Psychotherapeutic Best Practices for Children: Birth Through Five Years of Age

Psychiatric disorders presenting in young children are a public health concern, and they can negatively impact normative developmental trajectories in all spheres—social, emotional, and cognitive. One of the challenges in the field of behavioral health care for young children is the belief that young children cannot develop behavioral health disorders. Yet, these disorders if not recognized and appropriately diagnosed, may result in challenging behaviors, such as significant aggression toward others (e.g. biting, hitting, kicking) and emotional dysregulation (e.g. uncontrollable tantrums or crying). These behaviors, when not addressed can result in serious consequences such as child care expulsion, difficulty participating in family activities, and impaired peer relationships, making early intervention extremely important for families and caregivers that have young children with behavioral challenges.

Because of the complexities in treating infants and toddlers, the field of infant behavioral health has evolved to promote recognition of the rapid developmental processes and the importance of a healthy, secure child and parent/guardian/designated representative relationship. Given the unique needs of infants and toddlers, numerous therapeutic interventions exist, that can aid in reducing potentially damaging consequences. There is robust evidence supporting the use of relationship-based interventions, which focus on the child and parent/guardian/designated representative relationship. Generally, these treatment approaches focus on improving child and family/guardian/designated representative functioning relative to the identified emotional and/or behavioral challenges and can often be successful without introduction of pharmacological intervention.

In the absence of marked or sustained improvement, it may be necessary to follow the appropriate steps toward psychotropic intervention. However, "Psychotropic medications are only one component of a comprehensive biopsychosocial treatment plan that must include other components in addition to medication," according to American Academy of Child and Adolescent Psychiatry.

The use of medications to treat psychiatric disorders in young children raises unique developmental and ethical challenges. While considering whether medication should be introduced in treatment, the benefits of the medication must be evaluated and compared to the potential biological and psychosocial side effects.

Best practice recommends at least three months of extensive assessment and psychotherapeutic intervention prior to any consideration of psychopharmacological intervention.

Arizona has recognized the need to implement revised initiatives for young children to address psychotropic medication use. As of May 2016, AHCCCS provided analysis and trending of current psychotropic prescribing practices, particularly for young children and children in the foster care system.

AHCCCS has reorganized the prevailing practice guideline into five sections that align with current process within Arizona. Additional revisions focus on updated research and findings with regard to psychotropic prescribing practices. Focus has been added to align with current Maternal Child Health/Early and Periodic Screening Diagnostic and Treatment (MCH/EPSDT) practice, and Bright Futures. As such, the Guidelines within this document now comprise:

A. Assessment by Behavioral Health Professional/Provider,
B. Psychotherapeutic Interventions,
C. Psychiatric Evaluation,
D. Psychopharmacological Interventions, and
E. EPSDT: Assessing Physical and Behavioral Needs Through Developmental Surveillance, Anticipatory Guidance, and Social/Emotional Growth.

Please refer to the **AHCCCS AMPM Ch 210 Behavioral Health Practice Tool** for additional information on behavioral health screening, assessment, and treatment for children birth through five years of age.

Additional information can also be found in the **AHCCCS AMPM Ch 211 - Psychiatric and Psychotherapeutic Best Practices for Children: Birth through Five Years of Age**.

AHCCCS has historically incorporated the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program to ensure that members under the age of 21 receive appropriate preventive and early intervention services for physical and behavioral health conditions **(see AMPM Policy 430)**. Through formal policy and reporting requirements under CMS guidelines, participation has been measured in part through use of forms designated as “EPSDT Clinical Sample Template” **(see AMPM Policy 430 Attachment E)**.

AHCCCS requires that providers complete these screenings and assessments during the members EPSDT visit and submit the results to Mercy Care on the EPSDT Clinical Sample Template Form (or the equivalent electronic medical record). If a provider is unsure about which screening tools that are available or questions about the content within the EPSDT Clinical Sample template, they can find that information on the **Bright Futures website**.

AHCCCS Early and Periodic Screening, Diagnostic and Treatment Periodicity Schedule

AHCCCS MEDICAL POLICY MANUAL

POLICY 430 - ATTACHMENT A – AHCCCS EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT PERIODICITY SCHEDULE

PROCEDURE/AGE	Newborn	3-5 days	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 yrs	4 yrs	5 yrs	6 yrs	7 yrs	8 yrs	9 yrs	10 yrs	11 yrs	12 yrs	13 yrs	14 yrs	15 yrs	16 yrs	17 yrs	18 yrs	19 yrs	20 yrs
History Initial/Interval	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Length/Height & Weight	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Weight for Length	x	x	x	x	x	x	x	x	x	x																				
Head Circumference	x	x	x	x	x	x	x	x	x	x	x																			
Body Mass Index (BMI)											x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Blood Pressure – PCP should assess the need for B/P measurement for children birth to 24 months	+	+	+	+	+	+	+	+	+	+	+	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Nutritional Assessment	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Vision/Hearing/Speech	**SEE SEPARATE SCHEDULE**																													
Developmental Surveillance	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
General Developmental Screening 1							x			x		x																		
Autism-Specific Developmental Screening										x	x																			
Psychosocial/Behavioral Assessment (Social-Emotional Health)	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Alcohol and Drug Use Assessment																					+	+	+	+	+	+	+	+	+	+
Postpartum Depression Screening for Birthing Parent			x	x	x	x																								
Adolescent Suicide Screening																				x	x	x	x	x	x	x	x	x	x	x
Physical Examination	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Newborn Metabolic Screening 2	←	x	—	→																										
Immunizations	**SEE CENTERS FOR DISEASE CONTROL AND PREVENTION WEBSITE**																													

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Effective Dates: 03/01/19, 05/07/19, 03/01/19, 02/01/22, 10/01/22

Approval Dates: 10/23/06, 04/01/07, 10/1/08, 02/01/11, 04/01/14, 04/01/15, 10/18/18, 02/21/19, 04/16/20, 10/07/21, 07/14/22

AHCCCS MEDICAL POLICY MANUAL

POLICY 430 - ATTACHMENT A – AHCCCS EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT PERIODICITY SCHEDULE

PROCEDURE/AGE	Newborn	3-5 days	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 yrs	4 yrs	5 yrs	6 yrs	7 yrs	8 yrs	9 yrs	10 yrs	11 yrs	12 yrs	13 yrs	14 yrs	15 yrs	16 yrs	17 yrs	18 yrs	19 yrs	20 yrs
Tuberculin Test								+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Hematocrit/Hemoglobin							+	x	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Verbal Lead Screen						+	+	+	+	+	+	+	+	+	+	+														
Blood Lead Testing						+	+	x	+	+	x	+	+	+	+	+														
Dyslipidemia Screening											x			x+		x		x		x	x	x	x	x	x	x	x	x	x	x
Dyslipidemia Testing																				ONE TIME TESTING BETWEEN 18 AND 20 YEARS OF AGE										
STI Screening																				+	+	+	+	+	+	+	+	+	+	+
Cervical Dysplasia Screening																				+	+	+	+	+	+	+	+	+	+	+
Oral Health Screening by PCP[3]						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Topical Fluoride Varnish[4]						x →	→	x →	→	x																				
Dental Referral[5]						+	+	x	+	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Anticipatory Guidance	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

*** See Separate Schedules within AMPM Chapter 400 for Vision, Hearing/Speech, and Immunizations

[1] Utilization of one general developmental screening tool (e.g., ASQ and PEDS Tool) for members at 9, 18, and 30 months of age as described in AMPM 430.

[2] Newborn metabolic screening should be done according to state law. Results should be reviewed at visits and appropriate re-testing or referral done as needed.

[3] Oral health screenings to be conducted by the PCP at each visit starting at 6 months of age.

[4] Fluoride varnish is limited in a primary care provider's office to once every three 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.

[5] First dental examination may be performed as early as six months of age. Repeat every six months or as indicated by child's risk status/susceptibility to disease.

<u>These are minimum requirements.</u> If at any time other procedures, tests, etc. are medically indicated, the physician is obligated to perform them. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

Key:

x = to be completed

+ = to be performed for members at risk when indicated

← → x = the range during which a service may be provided, with the x indicating the preferred age

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Effective Dates: 03/01/19, 05/07/19, 03/01/19, 02/01/22, 10/01/22

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NOTE: If American Academy of Pediatrics guidelines are used for the screening schedule and/or more screenings are medically necessary, those additional interperiodic screenings will be covered.

NOTE: The American Association of Pediatric Dentistry recommends that dental visits begin by age one. Referrals should be encouraged by one year of age. Parents of young children may self-refer to a dentist within the Contractor's network at any time. -

AHCCCS MEDICAL POLICY MANUAL

POLICY 430 - ATTACHMENT A – AHCCCS EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT PERIODICITY SCHEDULE

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
VISION PERIODICITY SCHEDULE

PROCEDURE/ AGE	Newborn	3-5 days	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 yrs	4 yrs	5 yrs	6 yrs	7 yrs	8 yrs	9 yrs	10 yrs	11 yrs	12 yrs	13 yrs	14 yrs	15 yrs	16 yrs	17 yrs	18 yrs	19 yrs	20 yrs
Vision +	S	S	S	S	S	S	S	S	S	S	S	S	O*	O	O	O	S	O	S	O	S	O	S	S	O	S	S	O	S	S

These are minimum requirements: If at any time other procedures, tests, etc. are medically indicated, the physician is obligated to perform them.

Key:
- **S = Subjective, by history**
- **O = Objective, by a standard testing method**
- *** = If the member is uncooperative, rescreen in six months.**
- **+ = May be done more frequently if indicated or at increased risk.**

Ocular photo screening with interpretation and report, bilateral is covered for children ages three through six 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.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
HEARING/SPEECH SCHEDULE

PROCEDURE/ AGE	Newborn	3-5 Days	2 wks	By 1 mo	6 wks	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 yrs	4 yrs	5 yrs	6 yrs	7 yrs	8 yrs	9 yrs	10 yrs	11 yrs	12 yrs	13 yrs	14 yrs	15 yrs	16 yrs	17 yrs	18 yrs	19 yrs	20 yrs
Hearing/ Speech+	O**	S	O* ◄──	──────	──►	S	S	S	S	S	S	S	S	S	S	O	O	O	S	O	S	O	S	O	S	S	O	S	S	O	S	S

These are minimum requirements: If at any time other procedures, tests, etc. are medically indicated, the physician is obligated to perform them.

Key:
- **S = Subjective, by history**
- **O = Objective, by a standard testing method**
- *** = All children, including newborns, meeting risk criteria for hearing loss should be objectively screened.**
- **+ = May be done more frequently if indicated or at increased risk.**
- **** = All newborns should be screened for hearing loss at birth and again two to six weeks afterward if indicated by the first screening or if a screening was not completed at birth.**

Effective Dates: 03/01/19, 05/07/19, 03/01/20, 02/01/22, 10/01/22
Approval Dates: 10/23/06, 04/01/07, 10/01/08, 02/01/11, 04/01/14, 04/01/15, 10/18/18, 02/21/19, 04/16/20, 10/07/21, 07/14/22

mercy care

Immunizations/Vaccines

Successful strategies for childhood immunizations

According to recent literature, combinations of office-based systems- including chart and flagging for needed services, risk-assessment forms, flow sheets, and reminder/recall systems- can improve immunization rates. Studies have also found that providing patient and/or parent/guardian education using multiple strategies appear to be more effective than single efforts. Highlighted below are the current best practices.

Chart previewing

- Review patient records prior to the scheduled appointment to check for skipped or missed immunizations.
- Use the State or local registry to check for vaccinations that could be given at each visit.
- Review each patient's immunization status at all visits- including acute, chronic care and/or well-child appointments.

Parent communication

- Put parents at ease during children's immunizations.
- Distribute Vaccine Information Statements (VIS) prior to administering the vaccine.
- Explain the importance of immunizations to parents, be open and understanding towards parents' concerns. Use handouts to help in these discussions, and to answer further questions.
- Teach parents restraint techniques, comfort measures and aftercare.
- If parent/guardian does not wish to immunize their child/children have the parent sign the "Refusal to Immunize Form" and place in patients charts.

Office procedures

- Offer immunization-only appointments to increase accessibility.
- Take every opportunity that a patient is in the office to immunize him/her if appropriate.
- Maintain a manual list of patients whose parents/guardians are not compliant with recommended immunizations. Call the parents/guardians to have them bring their child in for an appointment.
- Give the parents/guardians an immunization schedule at their child's first visit.

Ongoing education and communication

- Produce printed labels for each of the vaccinations given to children. These labels should indicate the vaccine and lot numbers.
- When shots are administered, place a label in the progress note sections of the patient's chart, this helps reduce the amount of time spent on documenting such vaccines.
- Maintain procedures and/or proper documentation tools for all steps associated with immunizing a patient.

Childhood immunizations: Points to remember

1. Childhood immunizations required by 2 years of age (children should have the following shots BEFORE their 2nd birthday):
    - 4 DTap by 18 months
    - 3 IPV by 18 months
    - 3 Hep B by 18 months
    - 3 or 4 HIB (depending on the manufacture) by 18 months
    - 2 Hep A beginning at age 12 months with a minimum interval of 6 months
    - 1 MMR between 12 and 18 months
    - 1 VAR between 12 and 18 months
    - 4 PCV by 18 months
    - 2 or 3 RV (Rotavirus) by 8 months

2. **DTaP, IPV or Hib vaccinations administered prior to 42 days after births are invalid.**
3. The 4th dose of DTaP may be administered as early as 12 months of age, provided six months have elapsed since the 3rd dose. The 5th dose of DTaP is to be given between 4-6 years old.
4. **The 3rd dose of HepB must be given after six months of age.**
5. **If PRP-OMP (Pedvax Hib or Comvax HepB-Hib) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.**
6. When to document contraindications in ASIIS:
   - When child has had chicken pox- document **HISTORY** (contraindications) for the Varicella vaccine.
   - If the parent/guardians refuse vaccinations for their child due to religious or philosophical beliefs- document **PARENT REFUSAL** (vaccine deferrals) for all vaccines refused.
7. If parent/guardian does not wish to immunize their child/children have the parent sign the **"Refusal to Immunize Form"** and place in patients chart.
8. The HPV vaccine can be given to members as early has 9 years old, depending on health risk and/or sexual activity. The common age range for the HPV vaccine is 11-26, but can be given to members up through the age of 45.

Immunization/Vaccine Printable Resources

ADHS, CDC, and TAPI have multiple flyers, display posters, and pamphlets that can be used and handed out to our members. Items can be found at the links below:

- CDC Vaccine Chart (2023) - Printable: Birth Through Six Years Old
- CDC Vaccine Chart (2023) - Printable: 7-18 Years Old
- CDC Vaccine Chart (2023) - Printable: 19 Years and Older
- CDC Immunization Chart (2023): Child and Adolescent Schedule – Ages Birth to 18 Years Old
- CDC - Pregnancy and Vaccines
- CDC - Parents Who Question Vaccines
- CDC - Vaccine Education for Patients
- CDC - Talking to Parents about Vaccines
- CDC - Talking to Parents About HPV Vaccine
- ADHS - Talking to Parents About Vaccines
- TAPI - HPV Vaccine Campaign Materials

Creating an immunization friendly office environment

Providers are mandated under Arizona Revised Statute (A.R.S. §36-135) to report all immunizations administered to children from birth to 18 years of age using ASIIS.

Entering all immunizations (including historical records) into ASIIS is not only required but will result in fewer communications from health plans. Children who are up to date on their shots in ASIIS are not included in provider outreach or requests for records during audits. Per AMPM 430, Providers also need to document immunizations in ASIIS for members who are 19 and 20 years of age as well.

The Arizona State Immunization Information System (ASIIS) program offers tools and services to enhance the quality of your immunization service delivery.

ASIIS provides training the first Tuesday of each month and advanced classes are offered quarterly. In these trainings and classes, you will learn how to use the following features:

- **Reminder/recall postcard and labels:** Now you can send out reminders to get your patients back on time for their next series of immunizations.
- **Forecasting:** What shots does a child need next and when?
- **Access to millions of patient records and each patient's immunization history.**
- **Vaccines for Children Program vaccine accountability reports.**
- **A mean of electronically reporting your data to ASIIS**: Reduce your office's paper load and avoid data entry.

For more information or technical assistance regarding ASIIS:
Call **1-877-491-5741**, log onto **https://asiis.azdhs.gov**, or email **ASIISHelpDesk@azdhs.gov**.

Other important immunization phone numbers

Arizona Immunization Program office
Office 602-364-3630
https://www.azdhs.gov/preparedness/epidemiology-disease-control/immunization/index.php#contact-us

National Immunization Program
(CDC) 1-800-232-4636 (1-800-CDC-INFO)
https://www.cdc.gov/vaccines/hcp/index.html

Vaccines for Children Program
(VFC) 602-364-3642
https://www.azdhs.gov/preparedness/epidemiology-disease-control/immunization/index.php#vaccines-children-home

Arizona State Immunization Information System
(ASIIS) .... 602-364-3889 or 1-877-491-5741
https://www.azdhs.gov/preparedness/epidemiology-disease-control/immunization/asiis/index.php#contact

The Arizona Partnership for Immunization
(TAPI) 602-288-7568
www.whyimmunize.org

Arizona immunization program Vaccines for Children (VFC) & ASIIS

Background

The Vaccines for Children (VFC) Program is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. The program was officially implemented in October 1994 as part of the President's Childhood Immunization Initiative. Funding for the VFC Program allows the Centers for Disease Control and Prevention (CDC) to buy vaccines at a discount from the manufacturers and distribute them to state health departments and certain local and territorial public health agencies, which in turn distribute them at no charge to private physician offices and public health clinics registered as VFC providers.

Eligibility criteria

Children birth through 19 years of age who meet at least one of the following criteria on the day the vaccine is administered are eligible to receive VFC vaccine:

- Medicaid eligible: In Arizona, children whose health insurance is covered by the Arizona Health Care Cost Containment System (AHCCCS)
- Un-insured: A child who has no health insurance coverage
- American Indian or Alaska Native: As defined by the Indian Health Services Act
- Under-insured*:
  - A child who has commercial (private) health insurance but the coverage does not include vaccines,
  - A child whose insurance covers only selected vaccines (VFC-eligible for non-covered vaccines only),
  - A child whose insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured and is eligible to receive VFC vaccines.

Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC), County Health Departments and approved deputized providers are allowed to serve the VFC eligibility category of Underinsured. All other providers will only be allowed to serve the VFC eligibility categories of Medicaid, Un-insured, and American Indian/Alaskan Native.

Provider enrollment

Please type information into the enrollment documents and print to sign. VFC enrollment documents that are missing information will be returned for completion. If you are a first time VFC applicant please call the VFC office at **602-364-3642** before completing the enrollment packet.

Providers can find the VFC enrollment application on the ADHS Arizona Immunization Program website. The application and training certificates can be emailed to **arizonavfc@azdhs.gov** for processing.

VFC enrollment application: **https://www.azdhs.gov/documents/preparedness/epidemiology-disease-control/immunization/program-overview/az-new-vfc-provider-enrollment.pdf?v=20220621**

Vaccine storage & handling

Appropriate management of the program and components (i.e. vaccine storage and handling, eligibility screening, etc.) are critical to ensure good stewardship of the program and to ensure our children are being vaccinated effectively.

VFC & ASIIS Provider Responsibilities

Providers must coordinate with the **Arizona Department of Health Services** (ADHS) **Vaccines for Children** (VFC) program in the delivery of immunization services for Mercy Care members who are 19 years of age and under. Immunizations must be provided according to the Advisory Committee on Immunization Practices Recommended Schedule and be up-to-date.

- AHCCCS Providers must **enroll and re-enroll ANNUALLY** with the **VFC** program in order to see Medicaid EPSDT aged members, in accordance with AHCCCS Contract requirements.
- **AHCCCS EPSDT Providers that do not participate in the VFC program will have all of their EPSDT members reassigned to another provider that does participate in the program.**
- AHCCCS Providers shall not utilize AHCCCS funding to purchase vaccines covered through the VFC program for members younger than 19 years of age.
- AHCCCS Providers must document each EPSDT age member's immunizations in the Arizona State Immunization Information System (ASIIS) registry within 30 days of administration.

- Providers must also document immunizations in ASIIS for members who are 19 and 20 year of age.
- **AHCCCS Providers must maintain the ASIIS immunization records of each EPSDT member in ASIIS, in accordance with A.R.S. Title 36, Section 135.**
- **As of October 1, 2012,** federal vaccines can no longer be used to immunize privately insured children. Although a newborn may be eligible for Medicaid, hospitals cannot make an absolute determination that a newborn is not also eligible for private insurance at the time that this immunization would be administered. Because of this, the hospitals face the potential of administering VFC vaccines to newborns against the federal requirements. Since many hospitals have dis-enrolled from the VFC program due to this new policy, newborns who are delivered at the facilities may not receive the birth dose of the Hepatitis B vaccine.
- Mercy Care requests that all primary care providers and pediatricians caring for newborns, review each member's immunization records fully upon the initial visit, and subsequent follow-up visits, regardless of where the child was delivered. It is our intention to ensure that the newborns receive all required vaccines, and that those who have not received the birth dose of the Hepatitis B vaccine in the hospital be "caught up" by their primary care provider.

VFC and ASIIS Resources

The ADHS has provided some useful resources and job aides to ensure the providers are using the VFC and ASIIS systems correctly. Below is just a sample of the links providers can find on the ADHS website.

VFC

- Arizona VFC Program Operations Guide

ASIIS

- Ensure Your Office Submits Quality Data to ASIIS
- How to Log into ASIIS
- How to Search-Add-Edit a Patient Record in ASIIS

VOMS 2.0 (ASIIS Upgrade)

- How to Reconcile Inventory in ASIIS (VOMS 2.0)
- How to Create an Order in ASIIS (VOMS 2.0)
- How to Receive an Order in ASIIS (VOMS 2.0)
- Lot History Feature (VOMS 2.0)
- Vaccine Returns for Wasted and Expired Doses (VOMS 2.0)
- How to Create and Receive Transfers in ASIIS (VOMS 2.0)
- Tips to Ensure Doses are Properly Accounted for in ASIIS (VOMS 2.0)
- Tips for Finding Missing and Overused Doses in ASIIS (VOMS 2.0)
- How to View Order Tracking Numbers (VOMS 2.0)

Resources

- Defrosting Your Manual VFC Freezer
- Vaccine Sign - Caution Perishable Do Not Unplug
- Emergency Transport of Refrigerated Vaccines
- Frozen Vaccine Storage Requirements
- Required Specifications for Refrigerator and Freezer

- Vaccine Storage Temperatures
- Vaccines with Diluents - How to Use Them
- Unvaccinated Patient Guide
- AIPO Considerations for Curbside and Drive-Thru Immunization
- Hourly Vaccine Temperature Log for Outbreak Response

Data Loggers

- Data Logger Requirements
- VFC 400 Data Logger Training
- VFC Data Logger Cloud Training

Job Aids

- 2022 - 2023 Pediatric Influenza Vaccines
- AAP Parent Vaccine Refusal Form
- Are You a New Primary/Backup VFC Vaccine Coordinator?
- CDC's You Call the Shots Webinar and Certificate Instructions
- How to Inactivate Patients in ASIIS
- Inactivation Form
- Inactivation Checklist - VFC
- New VFC Facility/Change in Ownership or New Electronic Medical Record Checklist
- Adolescent Meningococcal Presentations

mercy care

Division of Developmental Disabilities (DDD) and Children's Rehabilitative Services (CRS)

Division of Developmental Disabilities (DDD)

DDD is a part of the Arizona Department of Economic Security (DES). It helps people with developmental disabilities achieve independence. It also provides support to family members and other caregivers.

Mercy Care provides services to DDD members in all 15 Arizona counties.

What is DDD?

DDD supports people who develop severe and/or chronic disabilities before their 18th birthday. These disabilities limit a person's ability to do the tasks related to daily living. A person may be eligible to receive developmental disability services if they have a diagnosis of:

- Cognitive/Intellectual disability
- Epilepsy
- Cerebral palsy
- Autism
- Developmental delays
- Down syndrome

Mercy Care provides physical and behavioral services to more than 15,000 members in the DDD/ALTCS program. In addition, children under age 3, who are suspected of having developmental delays, are also eligible for the Arizona Early Intervention Program (AzEIP). Early intervention is a process in which a group of therapists and educators works with parents and families of children with special needs to support a child's growth, development and learning.

DDD Requirements

The state's Division of Developmental Disabilities offers services to people who meet certain requirements.

To qualify for DDD, a member must:

- Be a resident of the state of Arizona
- Voluntarily apply
- Be at risk of having a developmental disability (up to age 6) OR a person aged 6 years to adulthood, have one of the following diagnoses:
  - Epilepsy
  - Cerebral palsy
  - Cognitive/intellectual
  - Autism
  - Down syndrome
- Have a disability that occurred prior to age 18
- Have substantial functional limitations in three of the seven major life areas, which include:
  - Self-care (eating, hygiene, etc.)
  - Receptive and expressive language
  - Learning
  - Mobility
  - Self-direction
  - Capacity for independent living
  - Economy self-sufficiency

Division of Developmental Disabilities (DDD) provider information

Mercy Care understands that taking children to the doctor can be challenging. These challenges are greater when your child has special needs. Parents of DDD members may need to schedule and attend extra appointments with specialists as well as coordinate care. As a result, well-child visits and immunizations are often missed or late.

Mercy Care has implemented outreach that focuses on reminding parents of DDD members how important preventative services are. For example:

- An article was included in our member's newsletter that reminded parents that even when there are many other appointments to attend, well visits and immunizations are still an important part of their child's medical care.
- Mercy Care is collaborating with DDD Support Coordinators when it will increase the quality of care that the member is receiving. For example, if a parent refuses to take their child in for a well visit, we will contact the DDD Support Coordinator to let them know. Discussing the issue with someone who is directly involved in their child's care may make a difference.
- Mercy Care provides specific outreach to providers that have a high number of members that are not up to date on immunization or well visits.
- During outreach calls to parents of DDD members referred to the dentist during a well-child visit, a list of dentist that have experience with special needs children will be referenced. This information is also included for you.

Process steps that can be helpful

- Complete a well-child exam and EPSDT form, even if the patient schedules an appointment for something else.
- Complete an EPSDT form for members that are a no show. This activates the Mercy Care EPSDT member outreach process.
- Make sure that the patient has been in recently before approving requests for DME or nutritional supplements.
- Set up an automatic reminder/recall system within your office so parents are notified by phone or mail when it's time for a well visit.

For more information:
Mercy Care website: www.MercyCareAZ.org

Division of Developmental Disabilities website (Arizona Department of Economic Security):
https://des.az.gov/services/disabilities/developmental-disabilities
Email: **DDDCustomerServiceCenter@azdes.gov**
Phone: **1-844-770-9500** (TTY **711**)
Fax: **602-542-6870**

Medical Benefits Specific to DD Members

If a member is enrolled in Mercy Care's DDD Program, in addition to all of Mercy Care's regular benefits, members enrolled with DDD/ALTCS have the following additional benefits:

Adaptive aids, which may include traction equipment, feeding aids (such as trays for wheelchairs), helmets, toileting aids, transfer aids and more. Once the primary care physician has determined that an adaptive aid is needed, the aids may be provided by Mercy Care. If Mercy Care denies the adaptive aid, but you still want it, you may purchase it on your own.

Incontinence briefs, including pull ups, are covered for members who are over 3 years of age to prevent skin breakdown and to enable participation in social, community, therapeutic and educational activities, when the following are met:

- The member has a disability that causes incontinence of the bowel and/or bladder.
- A prescription has been ordering the incontinence briefs.
- The request does not exceed 240 briefs per month, unless the member has chronic diarrhea or spastic bladder, and the submits evidence of medical necessity.
- The briefs are supplied by an "in-network" vendor.

The following are also covered for DD members:

- Custodial Nursing Facilities (SNFs)
- Emergency Alert Services
- Medically necessary practitioner visits to member's home
- Outpatient Speech therapy for members 21 years of age or older

If you have any questions, please call Mercy Care Member Services at **602-263-3000** or **1-800-624-3879** (TTY **711**), Monday through Friday from 7 a.m. to 6 p.m.

Once a member has been accepted into the DDD Program, the member can learn more about these services by contacting the DDD Liaison. Members can reach the liaison by calling Member Services at **602-263-3000** or toll free **1-800-624-3879**. Hearing impaired (TTY **711**).

DDD Dental Benefits

Dental services for DD members 21 years of age or older:

- Medically necessary comprehensive and preventive dental services, including dentures, up to $1,000 per plan year (plan year is October 1-September 31).
- Emergency dental services up to $1,000 per plan year.

Dental services for DD members under the age of 21:

- Comprehensive and preventive dental services, including oral health screenings, cleanings, fluoride treatments, dental sealant, oral hygiene education, x-rays, fillings, extractions, and other therapeutic and medically necessary procedures.
- Emergency dental services up to $1,000 per plan year.
- Members under 21 years of age do not need a referral for dental care.

Reduced Fee and Community Dental Clinics in Arizona

If a member loses AHCCCS eligibility, providers can redirect them to the available reduced fee and community dental clinic list provided by the Arizona Dental Association (AzDA) and Arizona Department of Health Services (ADHS). These dental providers often offer free or reduced dental care.

You can find the most up-to-date list on the ADHS website and here: **https://www.azdhs.gov/documents/prevention/womens-childrens-health/oral-health/reduced-fee-dental-clinics.pdf**

Dental Directory

Providers can find the dental provider search tool on the Mercy Care Website and the Dentaquest website. The Mercy Care Website will redirect to the Dentaquest website.

Mercy Care Website: https://www.mercycareaz.org/find-a-provider

- Select "Find a Provider"
- Scroll Down and Select "Find a Dentist"
- Select the members Line of Business
- Scroll Down and Select the option that best fits the member (selections below are examples of what is seen on the Dentaquest search page):
    - **Languages Spoken by Provider (choose the best fit)**
    - **Children with disabilities**
    - **Persons with autism spectrum disorder**
    - **Sedation Services for members with complex medical and behavioral conditions**

Dental Directory for special needs members

Dr. Blane Jackson
4550 E. Bell Rd., Bldg 1, Suite 102
Phoenix, AZ 85032
PH: (602) 485-1588

Dr. Blane Jackson (Rivers Edge Dental)
1185 N Arizona Blvd
Coolidge, AZ 85128
PH: (520)779-4246

Dr. Anthony Herro (Dental on Central)
5133 N. Central Ave, Suite 102
Phoenix, AZ 85012
PH: (602) 266-1776

Dr. David Jourabachi (Pediatric Dentist)
Pacific Dental Services – Foundation Dentists for Special Needs
4550 E Bell Rd Building 1 Suite 106
Phoenix, AZ 85032
PH: (818) 605-2081

Pediatric Dentist (Michael Lacorte Dds Pc)
8351 N Oracle Rd
Tucson, Az 85704
PH: (520) 297-5900

AT Stills Dental School Advanced Care Clinic (has sedation)
5855 E. Still Circle
Mesa, AZ 85206
PH: (480)-248-8100

Apple Valley Dental & Braces
5215 E Southern Ave
Mesa, AZ 85206 (Maricopa)
PH: (509) 823-4481

Children's Rehabilitative Services (CRS)

Information for our Children's Rehabilitative Services (CRS) members

Children's Rehabilitative Services (CRS) is a designation given to certain AHCCCS members who have qualifying health conditions. Members with a CRS designation can get the same AHCCCS covered services as non-CRS AHCCCS members. They are able to get care in the community, or in clinics called Multispecialty Interdisciplinary Clinics (MSIC). MSICs bring many specialty providers together in one place. Mercy Care DCS CHP will help a member with a CRS designation with closer care coordination and monitoring to make sure providers meet their special healthcare needs. AHCCCS Division of Member Services (DMS) determines eligibility for a CRS designation.

Who Is Eligible for CRS Designation?

AHCCCS members may be eligible for a CRS designation when they are:

- Under age 21; and
  - Have a qualifying CRS medical condition
  - A U.S. citizen or qualified resident

The medical condition must:

- Require active treatment; and
- Be found by AHCCCS DMS to meet criteria as specified in R9-22-1301-1305.

Anyone can fill out a CRS application including a family member, doctor or health plan representative. To apply for a CRS designation, you can mail or fax:

- A completed CRS application; and
- Medical documentation that supports that the applicant has a CRS qualifying condition that requires activetreatment.

Mail the documentation to:

Mercy Care Attn: CRS Department
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040

You can fax documentation to:

Mercy Care Member Services
Fax: 1-855-211-0798

Mercy Care will provide medically necessary care for physical and health services and care for the CRS condition.

Mercy Care is responsible for screening, evaluating, and providing medical treatment and rehabilitation for members under the age of 18 with a Children's Rehabilitative Services (CRS) qualifying chronic and disabling condition(s) as defined in A.A.C. R9-22-1303. Members must also be AHCCCS (Title 19) eligible to receive specialty care services.

CRS Multi-Specialty Interdisciplinary Clinics (MSICs)

Members with CRS qualifying diagnosis(es) are assigned to a Multi-Specialty Interdisciplinary Clinic (MSIC). MSICs are facilities where multiple providers in primary care, specialty care and behavioral health can meet with members and provide interdisciplinary services at the same location and appointment. The MSIC is where all the specialists can evaluate the member in a coordinated manner to provide the best care. At the MSIC, you can meet face-to-face with the member's care team and receive medical services.

CRS MSICs are at the following locations:

Central Region
DMG Children's Rehabilitative Services
3141 North 3rd Ave.
Phoenix, AZ 85013
602-914-1520 or 1-855-598-1871
https://www.dmgcrs.org/

South Region
Children's Clinics
Square & Compass Building
2600 North Wyatt Dr.
Tucson, AZ 85712
520-324-5437
1-800-231-8261
https://www.childrensclinics.org

North Region
Children's Rehabilitative Services
1200 North Beaver St.
Flagstaff, AZ 86001
928-773-2054
1-800-232-1018
https://nahealth.com/childrens-health-center/kids-special-healthcare-needs

Southwest Region
Children's Rehabilitative Services
Tuscany Medical Plaza
2851 South Ave. B
Building 25 #2504
Yuma, AZ 85364
928-336-7095 or 1-800-837-7309
https://www.yumaregional.org/Medical-Services/Pediatric-Care/Pediatric-Sub-Speciality-Clinic/Childrens-Rehabilitation-Services

CRS care team

The CRS Program uses a team approach to provide care for our members. Exactly who will be on their team depends on their special health care needs. They can get to know who is on their team by talking to their providers about their care and services. They can also add providers to their team. They would talk to their specialty clinic nurse to see how to do that.

Providers can help with this by openly discussing the care that is being provided to the member. They can also encourage the them to talk with each of their providers. This is a list of health providers that may be on their team:

Surgeons:

- Cardiovascular and thoracic surgeons
- General pediatric surgeons
- Ear, Nose and Throat (ENT) surgeons
- Neurosurgeons
- Ophthalmology surgeons
- Orthopedic surgeons (general, hand, scoliosis, amputee)
- Plastic surgeons

Medical specialists:

- Cardiologists
- Neurologists
- Rheumatologists
- General Pediatricians
- Geneticists
- Urologists
- Primary Care Providers

Behavioral health care providers and services:

- Psychiatrists
- Psychologists
- Residential Care Facilities
- Peer Support
- Crisis Services
- Inpatient Services
- Counseling (Individual, Family, Group)
- Child and Family Team
- Behavioral Health Day Program
- Community Mental Health Centers
- Substance Abuse (Assessment, Counseling, Medication Therapy)

Dental providers:

- Dentists
- Orthodontists
- Dental Hygienists

Can I stay in CRS after age 21?

Enrolled CRS members will lose their CRS designation the month of their 21st birthday. However, their providers and care will not change. Mercy Care will continue to be their AHCCCS Plan for all of their healthcare needs.

AHCCCS DMS may end a member's CRS designation for one of the following reasons:

1. The member loses Title XIX/XXI enrollment,
2. The member no longer meets the medical eligibility criteria for CRS,
3. The member has completed treatment for the CRS condition(s), or
4. The Member turns 21 years of age.

If there are questions about CRS benefits or services, you can call Member Services Monday through Friday from 8 a.m. to 5 p.m. at **602-262-3000** or toll-free **1-800-624-3879** (TTY **711**).

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Department of Child Safety Comprehensive Health Plan (DCS-CHP)

Department of Child Safety Comprehensive Health Plan (DCS-CHP)

The Mercy Care Department of Child Safety Comprehensive Health Plan (Mercy Care DCS CHP) is a comprehensive program administered by the Arizona Department of Child Safety (DCS). Mercy Care DCS CHP is the health plan for Arizona's children and youth placed in out-of-home care. enrolled with Mercy Care DCS CHP by their custodial agency (the agency that placed them in out-of-home care).

Children and youth become members of Mercy Care DCS CHP when they enter DCS care, and for as long as they remain in DCS care, or up to age 18. Children and youth stop receiving Mercy Care DCS CHP benefits when: They exit care through reunification, guardianship/adoption, when they turn 18 years old, or if they enter the juvenile detention system.

DCS CHP – Providing Care

Being removed from their home and placed in foster care is a difficult and traumatic experience for a child and their family. Many children are in foster care because they've experienced some form of serious abuse or neglect. When providing care for these members please have patience and understanding for their situation and treat their situation with care. Some common issues include poor verbal skills, poor sleep habits, poor appetite, anxiety, avoidance, or being fearful or angry.

DCS CHP members may also be enrolled in our specialty programs such as AzEIP, DDD, ALTCS, or CRS, depending on their individual needs and eligibility. If a provider believes that a member should be enrolled in one of these programs, be sure to notate the referral and/or coordination of care on the submitted well visit EPSDT form, as well as in the member's medical record.

DCS CHP – Mercy Care Outreach and Coordination of Care

DCS CHP is a sensitive population which requires confidentiality and requires timely care. Timely care and submission of documentation for our DCS CHP members is essential to their treatment plan. **DCS CHP members removed from their home must be seen by a provider within 30 days of enrollment. If members have not been seen within that timeframe or they do not show up for their appointments, please be sure to inform us at Mercy Care so we can help to coordinate care.** Mercy Care Outreach Staff and/or Care Management staff are here to help, and we may reach out to the providers office for assistance.

Mercy Care helps by contacting the providers office and/or members caregivers to:

- Assist in setting up appointments.
- Help caregivers with transportation to their appointments.
- Confirm with providers that referral appointments are being made.
- Assist providers in contacting the caregivers when members do not show up for EPSDT well visits.

DCS CHP – Claims Modifier TJ

As of 03/01/2023, Mercy Care has created a claims modifier to assist in billing for DCS CHP members. The modifier TJ is to be added when tracking our DCP CHP EPSDT members in Foster Care who require a specific visit within a specific time to meet policy requirements. This is not to be used for any other EPSDT visit. Please visit the **Mercy Care Provider webpage** for more information on the use of this modifier.

If you have any questions, contact Mercy Care DCS CHP Member Services: Monday through Friday, 8 a.m. to 5 p.m. at **602-212-4983** or **1-833-711-0776** (TTY: **711**).

DCS CHP – Resources

Below are some resources that can be utilized by providers and members/caregivers.

- AHCCCS Resources: **AHCCCS Foster and Kinship Caregivers Resources Packet**
- DCS Program: **Arizona DCS Program Policy**
- DCS CHP: **https://dcs.az.gov/services/chp**
- DCS Office of Prevention: **https://dcs.az.gov/services/prevention**

  This site includes links, phone numbers, and documents to help coordinate member safety. It also includes programs such as:
  - **Healthy Families**
  - **Regional Child Abuse Prevention Councils**
  - **Safe Sleep**

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Women’s Health Reminders

Well-Woman Preventative Care Visit

An annual well-woman preventative care visit is intended for the identification of risk factors for disease, identification of existing medical/mental health problems, and promotion of healthy lifestyle habits essential to reducing or preventing risk factors for various disease processes. As such, the well-woman preventative care visit is inclusive of a minimum of the following:

a. A physical exam (well exam) that assesses overall health.
b. Clinical breast exam.
c. Pelvic exam (as necessary, according to current recommendations and best standards of practice).
d. Review and administration of immunizations, screenings and testing as appropriate for age and risk factors.
e. Screening and counseling is included as part of the well-woman preventive care visit and is focused on maintaining a healthy lifestyle and minimizing health risks, that addresses at a minimum the following:
    i. Proper nutrition
    ii. Physical activity
    iii. Elevated BMI indicative of obesity
    iv. Tobacco/substance use, abuse, and/or dependency
    v. Depression screening
    vi. Interpersonal and domestic violence screening, that includes counseling involving elicitation of information from women and adolescents about current/past violence and abuse, in a culturally sensitive and supportive manner to address current health concerns about safety and other current or future health problems
    vii. Sexually transmitted infections
    viii. Human Immunodeficiency Virus (HIV)
    ix. Family planning services and supplies
    x. Preconception counseling that includes discussion regarding a healthy lifestyle before and between pregnancies that includes:
        a) Reproductive history and sexual practices
        b) Healthy weight, including diet and nutrition, as well as the use of nutritional supplements and folic acid intake
        c) Physical activity or exercise
        d) Oral health care
        e) Chronic disease management
        f) Emotional wellness
        g) Tobacco and substance use (caffeine, alcohol, marijuana and other drugs), including prescription drug use
        h) Recommended intervals between pregnancies
f. Initiation of necessary referrals when the need for further evaluation, diagnosis, and/or treatment is identified.

*Preconception counseling does not include genetic testing.

Testing for Sexually Transmitted Infections (STIs)

Arizona has seen a rise in sexually transmitted infections (STIs) in recent years. Some groups are more susceptible to health consequences of STIs. Any sexually active person can be infected with an STI. You can help keep members healthy by providing prevention education, vaccines, and testing.

Mercy Care covers these at **no cost** to the member:

- Screening and treatment for chlamydia, Syphilis, Gonorrhea, HIV and other STIs (males & females)
- Cervical cytology and HPV (women aged 21-29 every 3 years, women aged 30-64 every 5 years with HPV co-testing)
- HPV (Human Papillomavirus) immunizations (ages 9-45 for males & females)
- Syphilis testing for pregnant women at their first prenatal visit, during the third trimester of pregnancy, and at the delivery of the baby

The CDC also advises providers to test women over 25 years of age if they have a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has an STI.

To help partners get treated quickly, healthcare providers in Arizona may give infected individuals extra medicine or prescriptions to give to their sex partners. This is called expedited partner therapy or EPT. This is associated with fewer persistent or recurrent chlamydial infections and a larger number of partners getting treated. Partners should still be encouraged to seek medical evaluation.

For routine office visits, providers should test anyone that shows signs and symptoms of infection and anyone that has a partner that has recently been diagnosed.

The CDC recommends STI Screenings for the following people:

Who should be tested for chlamydia?

Women	• Women that are sexually active and are under 25 years of age • Women that are sexually active and are 25 years of age and older and if they are at increased risk • Retest approximately 3 months after treatment • Rectal chlamydial testing can be considered in females based on reported sexual behaviors and exposure
Pregnant Women	• All pregnant women that are under 25 years of age • All pregnant women 25 years of age and older if at increased risk • Retest during the 3rd trimester for women under 25 years of age or if they high risk • Pregnant women with chlamydial infection should have a test of cure 4 weeks after treatment and be retested within 3 months
Men Who Have Sex with Women	• There is insufficient evidence for screening among heterosexual men who are at low risk for infection, however, screening young men can be considered in high prevalence clinical settings (adolescent clinics, correctional facilities, STI/sexual health clinic)

Men Who Have Sex with Men	• At least annually for sexually active MSM at sites of contact (urethra, rectum) regardless of condom use2 • Every 3 to 6 months if at increased risk (i.e., MSM on PrEP, with HIV infection, or if they or their sex partners have multiple partners)
Transgender and Gender Diverse Persons	• Screening recommendations should be adapted based on anatomy, (i.e., annual, routine screening for chlamydia in cisgender women < 25 years old should be extended to all transgender men and gender diverse people with a cervix. If over 25 years old, persons with a cervix should be screened if at increased risk.) • Consider screening at the rectal site based on reported sexual behaviors and exposure
Persons With HIV	• For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter • More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology

Who should be tested for Syphilis?

Women	• Screen asymptomatic women at increased risk (history of incarceration or transactional sex work, geography, race/ethnicity) for syphilis infection
Pregnant Women	• All pregnant women at the first prenatal visit • Retest at 28 weeks gestation and at delivery if at high risk (lives in a community with high syphilis morbidity or is at risk for syphilis acquisition during pregnancy [drug misuse, STIs during pregnancy, multiple partners, a new partner, partner with STIs])
Men Who Have Sex with Women	• Screen asymptomatic adults at increased risk (history of incarceration or transactional sex work, geography, race/ethnicity, and being a male younger than 29 years) for syphilis infection
Men Who Have Sex With Men	• At least annually for sexually active MSM2 • Every 3 to 6 months if at increased risk2 • Screen asymptomatic adults at increased risk (history of incarceration or transactional sex work, geography, race/ethnicity, and being a male younger than 29 years) for syphilis infection
Transgender and Gender Diverse Persons	• Consider screening at least annually based on reported sexual behaviors and exposure
Persons With HIV	• For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter • More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology

Who should be tested for HIV?

Women	• All women aged 13-64 years (opt-out) • All women who seek evaluation and treatment for STIs
Pregnant Women	• All pregnant women should be screened at first prenatal visit (opt out) • Retest in the 3rd trimester if at high risk (people who use drugs, have STIs during pregnancy, have multiple sex partners during pregnancy, have a new sex partner during pregnancy, live in areas with high HIV prevalence, or have partners with HIV) • Rapid testing should be performed at delivery if not previous screened during pregnancy
Men Who Have Sex with Women	• All men aged 13-64 years (opt-out) • All men who seek evaluation and treatment for STIs
Men Who Have Sex With Men	• At least annually for sexually active MSM if HIV status is unknown or negative and the patient or their sex partner(s) have had more than one sex partner since most recent HIV test • Consider the benefits of offering more frequent HIV screening (e.g., every 3–6 months) to MSM at increased risk for acquiring HIV infection.
Transgender and Gender Diverse Persons	• HIV screening should be discussed and offered to all transgender persons. Frequency of repeat screenings should be based on level of risk

CDC Provider Resources: **https://www.cdc.gov/std/treatment-guidelines/provider-resources.htm**
This information can be found on the CDC website (Updated June 2022): **https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm**

Get an HPV vaccine
Vaccines are available that can help protect children and young adults against certain HPV infections. These vaccines protect against infection with the HPV types most commonly linked to cancer, as well as some types that can cause anal and genital warts.

These vaccines only work to prevent HPV infection – they will not treat an infection that is already there. It is most effective if given before a person becomes exposed to HPV (such as through sexual activity).

These vaccines help prevent pre-cancers and cancers of the cervix. Young adults age 11 through 26 who have not been vaccinated, or who haven't gotten all their doses, should get the vaccine as soon as possible. Vaccination of young adults will not prevent as many cancers as vaccination of children and teens. The HPV vaccine can be given as early as 9 years old, depending on health risk and/or sexual activity.

Some adults age 27 through 45 years who were not already vaccinated might choose to get HPV vaccine after speaking with their doctor about their risk for new HPV infections and possible benefits of vaccination for them. It's important to know that no vaccine provides complete protection against all cancer-causing types of HPV, so routine cervical cancer screening is still needed.

Breast Cancer Screening (BCS)

Key Statistics:

Breast cancer is the second-leading cause of cancer death in women. These are the American Cancer Society's estimates for breast cancer in the United States for 2023:

- About 297,790 new cases of invasive breast cancer will be diagnosed in women.
- About 55,720 new cases of carcinoma in situ (CIS) will be diagnosed.
- About 43,700 women will die from breast cancer.
- The chance a woman will die from breast cancer is about 1 in 39 (about 2.6%).

Who should be screened?

It is recommended that women who are 50 to 74 years old and are at average risk for breast cancer get a mammogram every two years. The decision to start screening with mammography in women prior to age 50 years should be an individual one.

Women who are 40 to 49 years old should talk to their doctor or other health care professional about when to start and how often to get a mammogram. Women should weigh the benefits and risks of screening tests when deciding whether to begin getting mammograms before age 50.

Cervical Cancer Screening (CCS)

Key Statistics:

The American Cancer Society's estimates for cervical cancer in the United States for 2023 are:

- About 13,960 new cases of invasive cervical cancer will be diagnosed.
- About 4,310 women will die from cervical cancer.

According to the American Cancer Society:

- Cervical pre-cancers are diagnosed far more often than invasive cervical cancer.
- Cervical cancer can often be found early and sometimes even prevented entirely, by having regular Pap tests. If detected early, cervical cancer is one of the most successfully treatable cancers.
- In the United States, Hispanic women are most likely to get cervical cancer, followed by African-Americans, American Indians, Alaskan natives, and Caucasians. Asians and Pacific Islanders have the lowest risk of cervical cancer in this country.
- Cervical cancer tends to occur in midlife, with the average age at diagnosis being 50. It rarely develops in women younger than 20. Many older women do not realize that the risk of developing cervical cancer is still present as they age. More than 20% of cases of cervical cancer are found in women over 65. However these cancers rarely occur in women who have been getting regular tests to screen for cervical cancer before they were 65. Start screening every woman at the age of 21, and continue with pap screening every 3 years until the age of 30.
- At 30 years of age women should have a Pap test and a human papillomavirus (HPV) co-test every 5 years until the age of 65. It is also acceptable to screen every 3 years with a Pap test alone.
- Women should be reminded to continue with yearly provider visits for well woman care and reproductive health care.

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Maternity Services

Maternity Services

Mercy Care assigns newly identified pregnant members to a PCP to manage their routine non-OB care. The OB provider manages the pregnancy care for the member and is reimbursed in accordance with their contract. A referral is not required for a member to see OB/GYN.

If a member chooses to have an OB as their PCP during their pregnancy, Mercy Care will assign the member to an OB PCP. If an OB provider has been assigned for OB services for a pregnant member, the member will remain with their OB PCP until after their post-partum visit when they will return to their previously assigned PCP.

Federal and state mandates govern the provision of EPSDT services for members under the age of 21 years. The PCP is responsible for providing these services to pregnant members under the age of 21, unless the member has selected an OB provider to serve as both the OB and PCP. In that instance, the OB provider must provide EPSDT services to the pregnant member.

Prenatal care, labor/delivery, and postpartum care services may be provided by a Licensed Midwife (LM) as long as it is within their scope of practice, and they are following the requirements listed out in.

Per **AMPM 410 - Maternity Care Services:** Maternity Care Services include, but are not limited to:

1. Medically necessary preconception counseling.
2. Identification of pregnancy.
3. Medically necessary education and prenatal services for the care of pregnancy.
4. The treatment of pregnancy-related conditions.
5. Labor and delivery services.
6. Postpartum Care.
7. Family Planning Services and Supplies.

Maternity Care Provider Requirements (AHCCCS AMPM Chapter 400)

- Follow ACOG standards of care, including use of a standardized medical risk assessment tool and ongoing risk assessment.
- High risk members are referred to a qualified provider and are receiving appropriate care.
- All pregnant members are screened through the Controlled Substances Prescription Monitoring Program (CSPMP) once a trimester; for those member receiving opioids, appropriate intervention and counseling shall be provided, including referral for behavioral health services as indicated for Substance Use Disorder (SUD) assessment and treatment.
- Screen all pregnant members for STIs, including syphilis at the first prenatal visit, third trimester, and at time of delivery.
- Educate members about healthy behaviors during pregnancy including the importance of proper nutrition, dangers of lead exposure to the birthing 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, prescription opioids use, interconception health and spacing, family planning options, including IPLARC options, and postpartum follow-up.
- All pregnant members shall receive a brief verbal screening and intervention for substance use utilizing an evidence-based screening tool and an appropriate referral shall be made as needed.

- Encourage initiation and duration of breastfeeding per evidence-based practices including skin-to-skin contact, no food or drink other than breastmilk (unless medically necessary), provider recommendation of breastfeeding, early initiation of breastfeeding, rooming in, etc.
- Conduct perinatal and postpartum depression screenings at least once during pregnancy and then repeat at the postpartum visit with appropriate counseling and referrals made if a positive screening is obtained
- Providers shall use any norm-referenced validated screening tool to assist in assessing the postpartum needs regarding depression, health care decisions and subsequent referrals for behavioral health services.
- Member medical records are maintained and document all aspects of maternity care provided
- Refer members for support services to the Special Supplemental Nutrition Program for WIC, as well as other community-based resources, to support healthy pregnancy outcomes including information about, and referrals to, home visitation programs for pregnant women and their children.
- Notify members that in the event of loss of eligibility for services, they may contact ADHS for referrals to low-cost or no-cost services. They can also go to the ADHS website to search for a provider/clinic: **https://www.azdhs.gov/audiences/clinicians/index.php#patient-search**
- 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 Contractor regardless of the payment methodology used.
- Postpartum services are provided within the postpartum period and utilize a separate "zero-dollar" claim for the postpartum visit
- Schedule postpartum visits during 3rd trimester or before discharge from hospital. Postpartum visit must be completed within the required time frame, which is prior to 12 weeks post delivery.

Prenatal, Pregnancy, and Postpartum Care Improvement Plan

Mercy Care has reviewed data and found a decline in the rates of compliance with timely prenatal and postpartum care visits. Due to this decline, Mercy Care has implemented a plan of action to help improve the care that our pregnant members are receiving. Provider participation is crucial to the success of this improvement plan.

Providers can help Mercy Care to monitor, evaluate, and improve patient/member outcomes by coordinating care and providing the services listed below:

- Provide treatment and follow up for any members that have health issue during the pregnancy, such as hypertension, gestational diabetes, obesity, or other health issues. Provide these members with:
  - Counseling on the importance of follow up care and attending their appointments
  - Counseling on any medication adjustments that might be needed.
  - Making referrals for any appropriate specialty care needed after delivery.
- Provide postpartum care within a timely manner, which is prior to 12 weeks post-delivery.
- Ensure that any inductions or cesarean sections done prior to 39 weeks are only performed if medically necessary and follow the ACOG guidelines.
- Monitor newborn weight by documenting low birth weight or very low birth weight and making a referral to an appropriate provider if necessary.
- Provide testing for sexually transmitted infections, including syphilis and HIV/AIDS at delivery.
- Provide COC by setting up the postpartum appointment after delivery, while the member is still in the hospital.
- Discuss and offer family planning services and supplies.
- Refer members to any appropriate community resources/programs.
- Screen members for postpartum depression during the postpartum visit and refer the member to a behavioral health provider if appropriate.

- If a member has a substance use disorder, provide COC with their SUD treatment provider.
- If a member is referred to a BH provider, provide COC with that provider to ensure an appointment is set and the member has attended the appointment.
- Have a safe plan of care in place prior to hospital discharge. This may include services such as behavioral health services, alternative infant care, and/or alternative nutritional supplementation if mother is breastfeeding.

Substance Use Disorder (SUD) During Pregnancy

Substance Use Disorders (SUDs) are treatable, chronic diseases characterized by a problematic pattern of use of a substance or substances leading to impairments in health, social function, and control over substance use. It is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite harmful consequences. Patterns of symptoms resulting from substance use (drugs or alcohol) can help a doctor diagnose a person with a SUD or SUDs. SUDs can range in severity from mild to severe and can affect people of any race, gender, income level, or social class.

Care provided to members with SUD should include:

- Consents for coordination of care with the member's SUD treatment provider
- An individualized plan of care that includes a naloxone prescription
- A pain treatment plan for delivery and postpartum
- A safe plan of care in place prior to discharge that includes alternative infant care and alternative nutritional supplementation if member is breastfeeding

Resources:

- **SHIFT** (Safe, Healthy Infants and Families Thrive) is a collaboration of a variety of providers within Maricopa County for expectant parents affected by SUD, in a non-stigmatizing, trauma and infant mental health informed manner. Examples include: MAT (Medication Assisted Treatment) and substance use treatment providers; Family Treatment Court; WIC (Women, Infants and Children); and others. Referrals can be made if the member is a pregnant parent with a SUD of any kind.

  MARICOPA SHIFT WEBSITE: **www.MaricopaSHIFT.com**
  EMAIL: **MaricopaSHIFT@maricopa.gov**
  PHONE: 602-526-6116

High risk maternal health care providers:

- Hushabye Nursery: **https://www.hushabyenursery.org/** or 480-628-7500
- Family Support & Home Visitation: **https://strongfamiliesaz.com/** for programs in your area
- AHCCCS: **https://www.azahcccs.gov/** or 602-417-4000 or 1-800-654-8713
- MCDPH: **https://www.maricopa.gov/5302/Public-Health** or 602-506-3011
- ADHS: **https://www.azdhs.gov/** or 602-542-0883

Newborn Screenings

The success of the Newborn Screening program depends on the coordinated efforts of many health professionals. Practitioners, hospitals, and laboratories work together to coordinate timely collection and rapid delivery of acceptable newborn screening specimens to the Arizona Public Health Laboratory (State Lab). Process steps are outlined below.

AHDS Updates

- The newborn screening fee is increasing to a single program fee of $171 (11/1/22)
- Newborn screening went digital July 1, 2021! If you still need access to newborn screening results, complete the **Online Newborn Screening Results Access Form - Providers** and submit to **srvaccounts@azdhs.gov**
- Tips on how to use SRV view: Secure Remote Viewer presentation or SRV- Quick Tips sheet
- **Insurance information and paperwork is no longer needed for submission with newborn screens.** Additional Information can be found here: **message about paperwork submissions.**

AHDS Additional Information and Resources

- **Newborn Screening- Resources to Get Started**
- **Arizona's Newborn Screening Panel of 33 disorders (1/1/2022)** – now includes **Spinal Muscular Atrophy (SMA)** and **X Linked Adrenoleukodystrophy (X ALD)**
- **Bloodspot/Heel Stick Screening**
  - **Providers are responsible for:**
    - Timely collection of properly identified
    - Ensuring the newborn screening specimens are acceptable
    - Rapid transfer of specimens to the Arizona Public Health Laboratory
    - Perform any follow-up on abnormal results
- **Hearing Screening & EHDI**
  - **First Hearing Screening:** All infants for hearing loss **by one month of age**
  - **Second Hearing Screening:** Complete a diagnostic testing **before three months of age** for any children who fail the first newborn hearing screen
  - Enrollment in Early Intervention services as soon as possible **(prior to 6 months of age)** after diagnosis of hearing loss

ADHS Educational Resources

- **Critical Congenital Heart Defects (CCHD)**
- **Disorder Information**
- **Education**
- **Forms**
- **Legal Requirements**
- **Responsibilities**
- **Talking to Parents**
- **New Providers**
- **Emergency Planning with Patients**

Family Planning

Family Planning

In order to allow members to make informed decisions, counseling should provide accurate, up-to-date information regarding available family planning methods and prevention of sexually transmitted diseases.

Provide counseling and education to members of both genders that is age appropriate and includes information on:

- Prevention of unplanned pregnancies.
- Counseling for unwanted pregnancies. Counseling should include the member's short and long-term goals.
- Spacing of births to promote better outcomes for future pregnancies.
- Preconception counseling to assist members in deciding on the advisability and timing of pregnancy, to assess risks and to reinforce habits that promote a healthy pregnancy.
- Sexually transmitted diseases, to include methods of prevention, abstinence, and changes in sexual behavior and lifestyle that promote the development of good health habits.
- Provide assistance to any members that will lose AHCCCS eligibility and help them find low or no cost primary care/family planning services. (Additional links can be found in the **Resource section** of this manual.)

Healthcare providers (including PCP's, Maternity Care Providers, and Pediatricians) are all required to discuss the availability of family planning services and supplies annually with any members of reproductive ages during their EPSDT visits, well woman visits, as well as during their Prenatal and Postpartum visits. This discussion should include the availability and benefits/risks of LARC (Long-Acting Reversible Contraceptive) and IPLARC (Immediate Postpartum Long-Acting Reversible Contraceptives). Contraceptives should also be recommended and prescribed for sexually active members. If a member's sexual activity presents a risk or potential risk, the provider should initiate an in-depth discussion on the variety of contraceptives available and their use and effectiveness in preventing sexually transmitted diseases (including AIDS). Such discussions must be documented in the member's medical record.

Full health care coverage and voluntary family planning services are covered.

The following services are not covered for the purposes of family planning:

- Infertility services including diagnostic testing, treatment services and reversal of surgically induced infertility
- Pregnancy termination counseling
- Pregnancy terminations
- Hysterectomies for the purpose of sterilization

The following are covered Family Planning Services & Supplies, at no cost to the member:

- Oral contraceptives
- Injectable contraceptives
- Intrauterine devices (IUDs)
- Diaphragms
- Condoms
- Foams
- Suppositories
- Natural family planning education or referral
- The morning-after pill
- Contraceptive counseling
- Sterilization (tubal ligation for women or vasectomy for men) for members 21 and older
- Pregnancy screening
- Screening and treatment for STIs (sexually transmitted infections) for both men and women

mercy care

Tobacco Cessation

Tobacco Cessation

Statistics show that 70% of all tobacco users think about quitting each year, and those that engaged in treatment did so because of the advice they received from a health care professional. Medication and Coaching can increase a person's success of quitting for good. Mercy Care encourages all providers to assess for tobacco use, code and bill for services and prescribe medication and coaching to their patients. The 'ASK, ADVISE, and REFER' model of care is an evidence based approach to ensuring that the patients get what they need, when they need it for tobacco cessation.

If you go to **https://www.mercycareaz.org/wellness/community-resources**, you will find tools needed for tobacco cessation which include a tobacco checklist for patients and a guide for providers to help them assess and code accordingly.

- Quit Tobacco for Patient: **https://www.ashline.org/**
- **https://www.cdc.gov/tobacco/campaign/tips/partners/health/index.html**
- Tobacco Free Arizona: **https://www.azdhs.gov/prevention/tobacco-chronic-disease/tobacco-free-az/index.php#health-issues-education**

We recommend for the coaching that you refer your patients to call ASHLine at **1-800-QUIT-NOW (1-800-784-8669)** or **1-855-DEJELO-YA (1-855-335-3569)**.

Or visit **www.ashline.org**.

The Arizona Smokers' Helpline (ASHLine) is a no cost to individual or provider, evidence-based resource to help your patients address tobacco and/or nicotine use and dependency. ASHLine helps indivuals by quitting or reduce use of smoking, chewing, and/or using other tobacco products (e.g., e-cigarettes). All patients must be asked about tobacco use and those that report using tobacco must be advised to quit and offered an evidence-based program like ASHLine.

ASHLine can also assist you and your team in becoming more comfortable discussing tobacco use with your patients. They can assist you with developing tobacco screening and intervention policies, and help you establish a referral process to the quitline.

All resources and technical assistance through ASHLine are at no cost to the individual.

ADHS has also created campaigns/programs to help with Tobacco Cessation:

- The Tobacco Control Program: **https://www.azdhs.gov/prevention/tobacco-chronic-disease/tobacco-control/**
- CIGNAL- program aimed at ages 15-24: **http://www.standaz.com/**
- Tobacco, Vape & E-Cigarettes: **https://www.azdhs.gov/prevention/tobacco-chronic-disease/tobacco-vape-e-cigarettes/index.php**

Quitting tobacco is tough — but medical professionals can make a difference!

A tobacco user is more successful in quitting when you offer help.

Step 1: Screen for tobacco and code appropriately

Try asking:

- "Do you smoke or use any type of tobacco?"
- "Did you know that smoking interacts with many medications? Because of this, we need to know whether our patients smoke so we can be sure they are getting the correct dosage of their medicines."
- Use clear, personalized language and be supportive.

ICD-10 Codes

F17.200 - Nicotine dependence, unspecified, uncomplicated
F17.201 - Nicotine dependence, unspecified, in remission
F17.203 - Nicotine dependence unspecified, with withdrawal
F17.208 - Nicotine dependence unspecified, with other nicotine-induced disorders
F17.209 - Nicotine dependence, unspecified, with unspecified nicotine-induced disorders
F17.210 - Nicotine dependence, cigarettes, uncomplicated
F17.211 - Nicotine dependence, cigarettes, in remission
F17.213 - Nicotine dependence, cigarettes, with withdrawal
F17.218 - Nicotine dependence, cigarettes, with other nicotine-induced disorders
F17.219 - Nicotine dependence, cigarettes, with unspecified nicotine-induced disorder
F17.220 - Nicotine dependence, chewing tobacco, uncomplicated
F17.221 - Nicotine dependence, chewing tobacco, in remission
F17.223 - Nicotine dependence, chewing tobacco, with withdrawal
F17.228 - Nicotine dependence, chewing tobacco, with other nicotine-induced disorders
F17.229 - Nicotine dependence, chewing tobacco, with unspecified nicotine-induced disorder
F17.290 - Nicotine dependence, other tobacco product, uncomplicated
F17.291 - Nicotine dependence, other tobacco product, in remission
F17.293 - Nicotine dependence, other tobacco product, with other nicotine-induced disorders
F17.299 - Nicotine dependence, other tobacco product, with unspecified nicotine-induced disorder
O99.330 - Smoking (tobacco) complicating pregnancy, unspecified trimester
O99.331 - Smoking (tobacco) complicating pregnancy, first trimester
O99.332 - Smoking (tobacco) complicating pregnancy, second trimester
O99.333 - Smoking (tobacco) complicating pregnancy, third trimester
O99.334 - Smoking (tobacco) complicating childbirth O99.335- Smoking (tobacco) complicating the puerperium
Z72.0 - Tobacco use
Z57.31 - Occupational hazard to environmental tobacco smoke
Z77.22 - Contact with and (suspected) exposure to environmental tobacco smoke (acute) (chronic)
Z87.891 - Personal history of nicotine
Z71.6 - Tobacco abuse counseling (need to use an F ICD-10 code listed above along with this)

MC-720 Last updated: 04/11/2017

Step 2: Advise the member to quit
Try saying:

- "Quitting tobacco is the very best thing you can do for your current and future health. If you are interested in quitting, then you will have more success if you take medication and work with a quit coach."

Step 3: Make a recommendation
Try saying:

- "I can prescribe medication for you at no cost to you. I can also refer you to the ASHLine to connect with a quit coach. They can help you put together your plan to quit. After I make the referral, the ASHLine will call you."

Step 4: Prescribe medication and refer to ASHLine
Try saying:

- "I am glad that you have agreed to quit tobacco. These medications are available at no cost to you. You do need a prescription, which I'll give to you. I also need your verbal consent to have an ASHLine coach call you."
- **Reinforce:** "You are going to have more success quitting now that you are getting both medication and coaching."

Covered Tobacco Cessation Medications (Covered for 90 days per 6 month period)

- Zyban and Zyban SR
- Chantix
- OTC Nicotine Replacement Therapy (patch, gum, lozenge)
- Rx Nicotine Replacement Therapy (Nicotrol inhaler, Nicotrol nasal spray)

Refer to ASHLine

- Electronic Health Record referral (if ASHLine referral is built into organization's EHR/EMR), or
- Customized ASHLine QuitFax referral form (paper form)

Billing codes

* For value-based contracting for tobacco cessation, use the billing codes below that include procedural codes (modifiers). These are considered Quality Data Codes
(QDC) and are used with the CMS-1500 CLAIM FORMS. Additional requirements for the form include:

1. Claim with QDC must have one quality measure diagnosis code referenced in the diagnosis pointer column.
2. Claim with QDC must include a face-to-face visit listed with QDCs.
3. QDCs must be billed with $0.00 (If your EMR does not accept $0.00 then use $0.01. The patient must not be billed for this amount.)

Procedure Code	Description
4004F*	Patient screened for tobacco use and received tobacco cessation intervention (counseling, pharmacotherapy, or both) if identified as a tobacco user
1036F*	Patient screened for tobacco use and identified as a non-user of tobacco
4004F-8P*	Tobacco screening OR tobacco cessation intervention NOT performed, reason not specified
99406	Smoking and tobacco cessation counseling visits for the asymptomatic patient, intermediate, greater than 3 minutes, up to 10 minutes
99407	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes

These codes were updated on May 22, 2017 and are subject to change. Always check the website below for the most recent information.

Resources:
www.MercyCareAZ.org

Need help training your staff?
Call Mercy Care at **602-263-3000** or **1-800-624-3879**.
Call Mercy Care RBHA at **602-586-1841** or **1-800-564-5465**.
Call Mercy Care DCS CHP at **602-212-4983** or **1-833-711-0776** (TTY: **711**).

Have questions about coding and billing?
Please speak with your Provider Relations representative.

mercy care

Home Visitation, Transportation, and Other Resources

Appointment Timeframes

Following AHCCCS ACOM 417, providers are required to schedule appointments for eligible members according to the standards listed below. Mercy Care is also here to help. We can help members set up their appointments when they call our member services department. If needed, the listing of our Member Services phone numbers can be found below in the transportation section.

PCP

- Routine Care – within 21 calendar days of the request
- Urgent Care – within 2 business days of the request
- Office Wait Time Requirements – less than 45 minutes

Specialist (including dental specialists)

- Routine Care – within 45 calendar days of the request
- Urgent Care – within 2 business days of the request
- Office Wait Time Requirements – less than 45 minutes

Dental

- Routine Care – within 45 calendar days of the request
  - For DCS CHP – within 30 calendar days of the request
- Urgent Care – within 3 business days of the request
- Office Wait Time Requirements – less than 45 minutes

Maternity

- 1st trimester – within 21 calendar days of the request
- 2nd trimester – within 7 calendar days of the request
- 3rd trimester – within 3 business days of the request
- High Risk – within 3 business days of identification of being high risk
- Office Wait Time Requirements – less than 45 minutes

Transportation Services

Mercy Care can help set up transportation for members to help them get to their appointments. If a member prefers to ride the bus, then we can send them bus passes or bus tickets at no cost. If our members need a ride, providers can inform them to call Mercy Care Member Services for help.

Members should call Member Services at least three (3) days in advance to get a ride. If they need a ride on the same day as the call, we may not be able to arrange a ride in time. We may be able to set up the ride if the visit is urgent. Members can also set up multiple appointments at one time. This is especially smart when setting regular appointments for visits like dialysis. After their appointment is over, the member calls the transportation provider to arrange a ride home.

If the ride is not set up in enough time, they may have to reschedule their appointment. If their appointment gets cancelled or changed to a different day or time, the member must call Member Services to cancel the transportation or have it changed to the new appointment time.

For Non-Urgent/Non-Emergent Transportation – The wait time standard is less than one hour before or after their appointment.

Tips for Getting a ride / Things to do Things not to do:

- DO call Mercy Care Member Services as soon as the appointment is made.
- DO call Mercy Care at least three (3) hours before an appointment for any that are made on the same day for urgent care.
- DO let us know if there are any special needs, like a wheelchair or oxygen.
- DO make sure the prescription is ready for pick up before calling for a ride.
- DON'T be late!.
- DON'T forget to call Mercy Care to cancel a ride if there is another one or if the appointment changes.
- DON'T wait until the day of the appointment to call for a ride.
- If it is a medical emergency, dial 911.
- Use of emergency transportation must be for emergency services only.

Mercy Care ACC-RBHA Member Services:
24 hours a day, 7 days a week at **602-586-1841** or **1-800-564-5465** (TTY: **711**).
24-hour nurse line: **602-586-1841** or **1-800-564-5465**

Mercy Care Member Services:
Monday through Friday, 7 a.m. to 6 p.m. at **602-263-3000** or **1-800-624-3879** (TTY: **711**).
24-hour nurse line: **602-263-3000** or **1-800-624-3879**

Mercy Care DCS CHP Member Services:
Monday through Friday, 8 a.m. to 5 p.m. at **602-212-4983** or **1-833-711-0776** (TTY: **711**).
24-hour nurse line: **602-212-4983** or **1-833-711-0776**

Loss of Eligibility

If a member loses AHCCCS eligibility, they can go to the ADHS website for lists of low cost, sliding scale, or no cost medical and dental providers. The member will have to call the clinics to find out about services and costs. The member can also refer to their member handbook, as all of the clinics are listed in there.

- ADHS Website: **https://www.azdhs.gov/audiences/clinicians/index.php#patient-search**
- ADHS Sliding Scale Fee Clinics: **https://www.azdhs.gov/prevention/health-systems-development/sliding-fee-schedule/index.php#clinic-locations**
- ADHS Reduced-Fee and Community Dental Clinics: **https://www.azdhs.gov/documents/prevention/womens-childrens-health/oral-health/reduced-fee-dental-clinics.pdf**

Home Visiting Resources

Strong Families AZ is a network of free home visiting programs that helps families raise healthy children ready to succeed in school and life. The programs focus on pregnant members and families with children birth to age 5.
https://strongfamiliesaz.com/

How To Sign Up

1. Select your county below to find the Arizona Health Start representative in your area.
2. Email or call the representative and let him or her know you're interested. He or she will help you determine if you're eligible and give you more information about registering.

Arizona Health Start

For women who are pregnant or have a child under 2 years old

If you are pregnant or a mother facing challenges, it's important to know that someone can help you. Arizona Health Start is here to help. Our home visitors can connect you with a variety of community organizations that provide health care, education, parenting resources, and application assistance for other programs. We will get to know you and your family, so we can help you get the resources you need. We understand your culture, because we live in your community. We also understand what you're going through, because we've helped families just like yours.

https://strongfamiliesaz.com/program/arizona-health-start/

Early Head Start/Head Start

For families with children under 5 years old

Head Start (for children 3-5) and Early Head Start (pregnant members and children 0-3) has a variety of program and service delivery options including Center Base, Home-Base, Combination (Home & Center) or Family Child Care. Each program incorporates an individualized approach to high-quality services for low-income pregnant members and children age birth to five. Families receive support and guidance from Head Start staff to become self-sufficient.

https://strongfamiliesaz.com/program/early-head-start/

Healthy Families Arizona

For families with an infant under 3 months old

Everyone who is having a baby can feel overwhelmed. It's important to know that it's ok to ask for help, especially if you're experiencing a number of challenges. Healthy Families Arizona is a free program that helps mothers and fathers become the best parents they can be. A Home Visitor will get to know you, and connect you with services based on your specific situation. To initiate services, please directly contact any of the service providers serving the area where you reside.

https://strongfamiliesaz.com/program/healthy-families-arizona/

Nurse-Family Partnership

For first-time birthing mothers less than 28 weeks pregnant

Children don't come with an instructional guide. So it's only normal that new birthing mothers face challenges and doubt. In times like these, someone is here to help you. Nurse-Family Partnership is a community healthcare program that will connect you with a nurse home visitor. Through the visits, you will learn how you can best care for your child.

https://strongfamiliesaz.com/program/nurse-family-partnership/

Parents As Teachers

For families with a child on the way or under 5 years old

Your children have so much potential. As a parent, you have a unique opportunity to be their first teacher. That's because most brain development occurs in the first few years of life, and you can make a difference. Parents As Teachers will show you how. Our Home Visitors will provide you with resources appropriate for your child's stage of development. Through Parents As Teachers, you'll develop a stronger relationship with your child and help prepare them for academic success.

https://strongfamiliesaz.com/program/parents-as-teachers/

Family Spirit

For Native American families with children under 3 years old

The ***Family Spirit Program*** is a culturally tailored home-visiting intervention delivered by Native American paraprofessionals as a core strategy to support young Native parents from pregnancy to 3 years post-partum. Parents gain knowledge and skills to achieve optimum development for their preschool age children across the domains of physical, cognitive, social-emotional, language learning, and self-help.

https://strongfamiliesaz.com/program/family-spirit-home-visiting-program/

High Risk Perinatal/Newborn Intensive Care Program

For families with newborns who have been in intensive care

The High Risk Perinatal Program/Newborn Intensive Care Program (HRPP/ NICP) is a comprehensive, statewide system of services dedicated to reducing maternal and infant mortality. The program provides a safety net for Arizona families, to ensure the most appropriate level of care surrounding birth as well as early identification and support for the child's developmental needs.

https://strongfamiliesaz.com/program/high-risk-perinatal-programnewborn-intensive-care-program/

SafeCare

For families with a child under 5 years old

Let professional and highly trained home visitors support you and your family on your journey to success. Utilizing the nationally recognized SafeCare model, you will receive weekly visits that are divided into core focus areas: parent-child interaction, health and home safety. In each focus area or module, you will build on and strengthen your skills through a variety of interactive sessions.

https://strongfamiliesaz.com/program/safecare/

Additional Resources

Parents Partners Plus

Partners with trusted, established nonprofit and advocacy organizations to help give your child his or her best possible chance at a happy, healthy future. If you have questions, concerns or needs as far as breastfeeding, fighting postpartum depression, helping your child meet developmental milestones or birthing mothers transitioning into life as a parent, our representatives can connect you with critical resources.

Maricopa County Referral Resource
(602)633-0732
https://parentpartnersplus.com/

Power Me A2Z

Free vitamins for young women for strong bones and teeth, shiny hair, strong nails, a healthy immune system, and preventing anemia. Taking a daily vitamin provides enough of each nutrient if you can't get it through what you eat every day. Good vitamins are also important for women's health by reducing the risk of heart disease, colon cancer, memory loss, and prevent certain birth defects when you're ready for children. Provided from the Arizona Department of Health Services (ADHS) for Arizona women over 18 years of age.

https://www.powermea2z.org/

ADHS Pregnancy and Breastfeeding Helpline
Provided by the Arizona Department of Health Services (ADHS) and offers information about pregnancy tests, and low-cost providers. Calls are answered by an International Board-Certified Lactation Consultant (IBCLC) to learn about the benefits of breastfeeding, mom's diet, milk supply, or tips and tricks for successful breastfeeding for birthing mother and child.
1-800-833-4642, available 24 hours a day, seven days a week.
https://www.azdhs.gov/prevention/nutrition-physical-activity/breastfeeding/index.php

Office of Women and Children's Health
150 N. 18th Ave.
Phoenix AZ 85007
602-542-0883

Postpartum Support International
The mission of Postpartum Support International is to promote awareness, prevention, and treatment of mental health issues related to childbearing in every country worldwide.
PSI Helpline: 24/7 toll free 1-800-944-4773 (English) or text "Help" to 971-203-7773 (Espanol).
https://www.postpartum.net/

Birth to 5 Helpline
The Birth to 5 Helpline is open to all Arizona families with young children looking for the latest child development information from experts in the field. Professionals may also take advantage of this service. Call to speak with of our bilingual (English/Spanish) early childhood specialists on duty **Monday through Friday from 8:00 a.m. to 8:00 p.m.** You can also leave a voicemail or complete our online contact form.
(877)705-KIDS
https://www.swhd.org/programs/health-and-development/birth-to-five-helpline/

Fussy Baby Program
The Fussy Baby program is a component of the **Birth to Five Helpline** and provides support for parents who are concerned about their baby's temperament or behavior during the first year of life. Our clinicians will work with you to find more ways to soothe, care for, and enjoy your baby. We'll also offer ways to reduce stress while supporting you in your important role as aparent.
(877)705-KIDS
https://www.swhd.org/programs/health-and-development/fussy-baby

Hushabye Nursery
Hushabye's Nursery's mission is to embrace substance exposed babies and their caregivers with compassionate, evidence-based care that changes the course of their entire lives. They offer a safe and inclusive space where the birthing parents and babies can receive integrative care therapeutic support that offers each child the best possible life outcomes.
Call or text to (480)628-7500
https://www.hushabyenursery.org/

Center for Health and Recovery (CHR)
Center for Health and Recovery (formerly known as CHEEERS Recovery Center) is a non-profit community service agency serving adults with behavioral health challenges. They provide Recovery Support Services through classes, groups, events, and one-on-one support, by state-certified CHR Peer Support Specialists.
(602)246-7607
www.azchr.org

Jacob's Hope
Jacob's Hope is a care center for newborns who are suffering with Neonatal Abstinence Syndrome, or withdrawals from prenatal exposure to drugs. Their staff of caring RNs and CNAs provide 24-hour nurturing medical care for infants while the drugs leave their system. They show moms and caregivers how to console your baby—without judgement.
(480)398-7373
https://jacobshopeaz.org/

Lifewell Women's Residential
Members receive intensive, supervised treatment in a therapeutic, structured and safe environment, as well as childcare, laundry and family-style dining. They target change that facilitate a sober lifestyle and improvement in the overall ability to function as a contributing member of the community.
(602)808-2800
https://www.lifewell.us/residential-treatment/

First Things First
Partners with families and communities to help our state's young children be ready for success in kindergarten and beyond.
(602)771-5100 or (877)803-7234
https://www.firstthingsfirst.org/

Southwest Human Development
Works with families from pregnancy through the first 5 years of life to become the best parent you can be.
(602)266-5976

Maricopa County Lead Safe Phoenix Partnership
Provides the following services to families enrolled in the Lead Safe Phoenix program:

Home Visitation

- Lead blood testing for children under 6 years of age
- Environmental assessment of the home to enhance the health and safety of the children in the home
- Education on the prevention of lead poisoning
- Screening and referral to community resources as needed

Community Education and Outreach

- Education regarding lead hazards and lead poisoning prevention to target populations (pregnant members, households with children under six) within Lead Safe Phoenix eligible zip codes
- Education to home visiting program staff working within the Lead Safe Phoenix target zip codes

(602)525-3162
https://www.maricopa.gov/1853/Lead-Poisoning-Prevention

Poison Control
Call **911** right away if the individual collapses, has a seizure, has trouble breathing, or can't be awakened.

For immediate and expert advice that's free and confidential call 24 hours a day, seven days a week call: **1-800-222-1222**.

Get help online if you took too much medicine, swallowed or inhaled something that might be poisonous, splashed a product on your eye or skin, help identify a pill, or information about a medication.
https://www.poison.org/

WIC
WIC serves women who are pregnant, are breastfeeding an infant up to one year old plus infants and children up to the age of 5. WIC Your Way (WYW) offers families an opportunity to do their WIC appointment from home.
1(800)252-5942
https://www.azdhs.gov/prevention/azwic/index.php
https://www.maricopa.gov/1491/Women-Infants-Children-WIC