Prevention and Wellness Provider Outreach Manual

www.MercyCareAZ.org
MC-1511-2

Follow us @MercyCareAZ

Table of Contents

Early and Periodic Screening, Diagnostic and Treatment Program 5

Early And Periodic Screening, Diagnostic and Treatment (EPSDT) Services Description 6
Well Child Visit CPT codes – ages 0 months to 20 years of age 9
Well visits and sports physicals 9
Sick visit performed in addition to a well visit 9
Successful strategies: Reducing missed appointments 10
Mercy Care Can Help Reschedule Missed Well Visits 10
Vision and Hearing screenings 11
Oral Health Screenings During the Well Visit 11
Dental Home 12
Fluoride Varnish Application by PCP 12
Reduced Fee and Community Dental Clinics in Arizona 13
Dental/Oral Health Resources 13
AHCCCS Dental Periodicity Schedule 14
Monitoring BMI 15
Appropriate Weight Gain and Nutrition Resources 15
Nutritional Assessment and Nutritional Therapy 16
TB Monitoring & Testing Requirements 18
Blood Lead Screening and Testing 18
Blood Lead Testing Recommended Schedule 18
Provider Requirements for Elevated Blood Lead Levels (EBLL) 19
Blood Lead Level Testing Resources 19
AzEIP 19
AzEIP Coordination of Care Process 20
AzEIP PCP Initiated Service Requests 20
AzEIP Initiated Service Requests 22
Additional AzEIP Resources 23
Developmental Surveillance 23
Developmental Screening 23
Developmental Screening Claims 24
Developmental Screening Resources 25
EPSDT Provider Audits – Screenings, Trainings, and Documentation 25
Autism Spectrum Disorder Resources 26
Behavioral Health Screenings, Referrals and Follow up Requirements 27

Behavioral Health Serious Mental Illness (SMI) Referrals 28
Arizona Pediatric Psychiatry Access Line (Pediatric A-PAL) 28
AHCCCS Navigating the Behavioral Healthcare System 29
Behavioral Healthcare System Resources - Section A 30
Adolescent Suicide and Depression Screening 31
Adolescent Substance Use Disorder (SUD) Screening 31
Suicide Prevention and SUD Screening Resources 32
Perinatal Mood and Anxiety Disorder (PMAD) Screening of the Birthing Parent 32
Perinatal Mood and Anxiety Disorder (PMAD) Educational Resources 33
Psychiatric and Psychotherapeutic Best Practices for Children: Birth Through Five Years of Age 33
AHCCCS EPSDT Periodicity Schedule 35
Immunizations/Vaccines 38
Successful Strategies for Childhood Immunizations 39
Childhood Immunizations: Points to Remember 39
Immunization/Vaccine Printable Resources 40
Creating an Immunization Friendly Office Environment 40
Other Important Immunization Phone Numbers 41
Arizona Immunization Program Vaccines for Children (VFC) & ASIIS 41
VFC & ASIIS Provider Responsibilities 42
VFC and ASIIS Resources 43
Division of Developmental Disabilities (DDD) and Children's Rehabilitative Services (CRS) 45
Division of Developmental Disabilities (DDD) 46
Division of Developmental Disabilities (DDD) Provider Information 47
DDD Medical Benefits 47
DDD Dental Benefits 48
Reduced Fee and Community Dental Clinics in Arizona 48
Dental Directory 49
Dental Directory for Special Needs Members 49
Children's Rehabilitative Services (CRS) 50
CRS Multi-Specialty Interdisciplinary Clinics (MSICs) 51
CRS Care Team 52
Department of Child Safety Comprehensive Health Plan (DCS-CHP) 54
Department of Child Safety Comprehensive Health Plan (DCS-CHP) 55
DCS CHP – Providing Care 55
DCS CHP – Appointment Timeframes 55
DCS CHP – Mercy Care Outreach and Coordination of Care 55

DCS CHP – Resources 56
Women's Health Reminders 57
Well-Woman Preventative Care Visit 58
Mercy Care Can Help Reschedule Missed Women's Wellness Visits 59
Testing for Sexually Transmitted Infections (STIs) 59
Cervical Cancer Screening (CCS) 62
Breast Cancer Screening (BCS) 63
Maternity Services 64
Maternity Services 65
Maternity Care Provider Requirements 65
Prenatal, Pregnancy, and Postpartum Care Improvement Plan 67
Addressing Perinatal Mood Disorders and Anxiety 68
Perinatal Mood and Anxiety Disorder Resources 70
Substance Use Disorder (SUD) During Pregnancy 70
Substance Use Disorder (SUD) During Pregnancy Resources 70
Maternity Provider Audits – Screenings and Documentation 71
Breastfeeding Guidance and Education 71
Newborn Screenings 71
Family Planning 73
Family Planning Services and Supplies 74
STI Testing Provider Audits 75
Tobacco Cessation 76
Tobacco Cessation 77
Quitting tobacco is tough — but medical professionals can make a difference! 77
Timeframes, Transportation, Eligibility, and Referrals 80
Appointment Timeframes 81
Transportation Services 82
Loss of Eligibility 83
Referrals 83
Home Visitation Programs and Other Community Resources 85
Home Visitation Program Resources 86
Additional Community Resources 88

mercy care

Early and Periodic Screening, Diagnostic and Treatment Program

Early And Periodic Screening, Diagnostic and Treatment (EPSDT) Services Description

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program covers all medically necessary, mandatory, and optional treatments and services listed in Federal Law 42 USC 1396d (a) to correct or ameliorate defects and physical and behavioral illnesses and conditions whether or not the services are covered under the AHCCCS State Plan, Rules, or Policies for AHCCCS members less than 21 years of age. The purpose of EPSDT is to ensure the availability and accessibility of health care resources and to assist members and their parents, guardians, or caregivers in effectively using these resources.

The EPSDT program provides comprehensive health care through primary prevention, early intervention, diagnosis, screening, rehabilitative services, medically necessary treatment, and follow-up care of physical and behavioral health conditions. Examples of services that are included in the EPSDT program are inpatient and outpatient hospital services, laboratory and x-ray services, physician services, naturopathic services, nurse practitioner services, health screenings, vision and hearing screenings, preventative care, medications, dental services, therapy services, behavioral health services, medical equipment, medical appliances and medical supplies, orthotics, prosthetic devices, eyeglasses, transportation, family planning services and supplies, well woman preventive care services, and maternity care services when applicable. EPSDT does not include services that are experimental, that are solely for cosmetic purposes, or that are not cost effective when compared to other interventions. Additional details can be found in the AHCCCS EPSDT Periodicity Schedule (Policy 430, Attachment A) and AHCCCS Dental Periodicity Schedule (Policy 431, Attachment A).

The Centers for Medicare and Medicaid Services (CMS) requires AHCCCS to provide specified services to our EPSDT population. Therefore, AHCCCS redesigned the age-specific EPSDT Clinical Sample Templates (EPSDT Forms) to assist providers to ensure that the required services are performed at a specific age and a specific well visit. This will ensure that our members are provided an opportunity to receive preventive care with a more targeted approach. The most recent EPSDT Forms are effective 11/28/2023.

Providers must use the *most up-to-date* EPSDT Form Clinical Sample Templates located on the AHCCCS website. Mercy Care also accepts the members electronic medical record (EMR) as long as the *equivalent age-specific information* is included. Mercy Care will continue to provide two-part carbonless EPSDT Form Clinical Sample Templates to providers. If providers use hard copy EPSDT Forms, the provider must ensure they are using the most recent EPSDT form based on the members age on that date of service. Providers can find the EPSDT Form Clinical Sample Templates here: AMPM 430 - Attachment E and the Mercy Care Provider Website - Under Forms.

Requirements for EPSDT providers

PCPs are required to comply with regulatory requirements as well as 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 (VFC) Progra**m.
- Provide all appropriate immunizations according to the Advisory Committee on Immunization Practices Recommended Schedule as specified in the CDC recommended age specific immunization schedules, AMPM Policy 310-M, and the ADHS school immunization requirements.
- Ensure that families receive evidence-based breastfeeding information and support including information on breast pumps, if appropriate.
- Education about the dangers of blood lead poisoning, blood lead screening, blood lead testing for high-

risk members through age six, and **testing members at their 12 month and 24 months well visits**.

- Providing all screening and testing services according to the AHCCCS EPSDT Periodicity Schedule and community standards of practice. The 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 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
    4750 S. 44th Place, Ste. 150, Phoenix, AZ 85040
- Do not send hard copies of EPSDT forms to the AHCCCS office. They must be submitted to Mercy Care by using the above fax number or mailing address.
- Provide health counseling and/or education at initial and follow-up visits.
- 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 or receive immunizations.
- 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 national coding standards and applicable modifiers.
- Referring Mercy Care members (ACC and DD) to Children's Rehabilitative Services (CRS) when they have conditions covered by the CRS program.
- Providing nutritional screening to assess the need for metabolic medical foods, nutritional therapy, and/or nutrition referrals.
- Providing oral health services such as oral health screenings and fluoride varnish applications.
- Referring members as soon as possible to behavioral health crisis services per instructions in the provider manual, when appropriate. Do not wait. Member safety is the number one priority.
- Referring members to community resources such as WIC, Raising Special Kids, ADHS Breastfeeding Hotline, 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 two years and 10 months of age with developmental disabilities that need services, family education, and family support.
- Initiating and coordinating referrals to specialists and behavioral health providers if necessary.
- Using the appropriate clinical guidelines, assessment tools, and algorithms to aid in treatment decisions when treating behavioral health conditions that are within your scope of practice.
- Discuss family planning services and supplies with any members that are of reproductive age or members that are sexually active.
- Address any social determinants of health (SDOH) and barriers to care the member may be experiencing. Providers should also share this information with Mercy Care so we can provide additional outreach.

A well visit includes the following basic elements:

- Comprehensive health and developmental history, including growth and development screening (includes physical, nutritional and behavioral health assessments).
- Comprehensive unclothed physical examination.
- Appropriate immunization education/counseling and administration 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, reducing risky behaviors (such as safe sex, not smoking, drinking alcohol, or doing illegal drugs), as well as accident and disease prevention.
- Appropriate oral health screening and referral.
- Fluoride varnish application in the PCP office once every three months for children who have reached six months of age with at least one tooth erupted, with recurrent applications up to five years of age.
- Appropriate vision and hearing/speech testing.
- Screening for age-appropriate weight gain. Use the CDC growth charts and BMI percentile for children 24 months and older. Use the World Health Organization (WHO) growth charts for children under 24 months. The CDC also has growth charts available for children with Down syndrome.
- Anticipatory guidance should be provided so that parents or guardians know what to expect in terms of the child's developmental milestones as noted in the CDC and AAP "Learn the Signs. Act Early." program.
- Health education, counseling, and chronic disease self-management.
- Providing the following behavioral health screenings, using a validated screening tools, saving the tools to the members medical records, and providing timely referrals for members with positive results:
- General Developmental screening for members age 9, 18 and 30 months.
- Autism Specific developmental screening for members age 18 and 24 months.
- Screening adolescents for suicide and depression annually starting at 10 years old.
- Screening adolescents for a substance use disorder (SUD) annually starting at 12 years old.
- Screening adolescents for syphilis annually starting at 15 years old.
- Screening the birthing mother for postpartum depression at the 1st, 2nd, 4th, and 6th well visit.
- Saving all screening tools in the members medical records.

EPSDT 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 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.

Well Child Visit CPT codes – 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

You can find additional code and modifier details that are covered during a well visit in the document: **AMPM 430 EPSDT Service Codes - Updated 11/20/23.** This document can be found on **the AHCCCS website under - Plans & Providers - Medical Coding Resources**.

Well visits and sports physicals

Well visits for sports and other activities should be based on the most recent well visit, as the annual well 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 well 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.

Sick visit performed in addition to a well visit

Billing a "sick visit" (CPT Codes 99202-99215) at the same time as a well 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/abnormality is significant enough to require additional work to perform the key components of a problem-oriented evaluation and management (E/M) service.
- Do not bill an additional E/M code if the problem/abnormality is insignificant or trivial and does not require additional work.
- 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 a "well visit" are not to be considered when determining the level of the additional service (CPT Code 99202-99215).
- 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 well visit codes and sick visit codes to indicate that a significant, separately identifiable E/M 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.*

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. What date would like to reschedule to?"
- 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 Can Help Reschedule Missed Well Visits

To help address 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 them listing the date and time of the appointment.
- If the patient misses an appointment, notify the EPSDT/MCH Department and our outreach staff will contact the member by letter and phone to assist them in rescheduling their appointment. During the phone call, the member will also receive education on the importance of showing up for scheduled appointments.
    - A couple examples of ways a provider can notify the plan, is through submitting an **EPSDT Clinical Sample Template Form** or by completing the **EPSDT/MCH Missed Appointment Log**. Both of these can be found on the Mercy Care Provider Website – Under Provider Forms.

Vision and Hearing screenings

Eye Examinations and Prescriptive Lenses

EPSDT includes eye exams, frames, and prescriptive lenses to correct or ameliorate defects, physical illness and conditions. PCPs are required to perform basic eye exams during well visits 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, members do not need to wait for their next scheduled well visit. Ocular photo screening with interpretation and report, bilateral (CPT code 99177) is covered for children ages three to six as part of the well 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 periodicity schedule. Audiology screenings can happen on an inpatient or outpatient basis and an 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 well 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 for questions 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.

You can find additional details on EPSDT WCV, Vision, Hearing, and Speech CPT codes as well as the required modifier details in the AMPM 430 EPSDT Service Codes Document - Updated 11/20/23.
This document can be found on the AHCCCS website under - Plans & Providers - Medical Coding Resources.

Oral Health Screenings During the Well Visit

As part of the physical examination, an oral health screening must be part of an well visit conducted by a physician, physician's assistant, or nurse practitioner. The oral health screening must be done at each visit to identify those members that will require a dental referral for an evaluation and treatment. An oral health 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 and the AHCCCS Dental 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. PCPs must refer members to a dentist by one year of age. Evidence of this referral must be documented on your submitted EPSDT Form and in the member's medical record. The member will be assigned to a dental home on enrollment or by 6 months of age, whichever comes first. Be sure to address any barriers to care the member may be experiencing. Providers can also share this information with Mercy Care so we can provide additional outreach.

Dental Visit Timeframes

Per AHCCCS Policy 431- Dental Periodicity schedule and AHCCCS Policy 430- EPSDT Periodicity schedule, PCPs

should be encouraging members to have their first dental appointment by age one and every six months thereafter. EPSDT members can also self-refer to an AHCCCS registered dentist. Per ACOM 417, PCPs shall refer a member to a dentist according to the following timeframes:

- **Urgent** - As expeditiously as the member's health condition requires but no later than three business days from the request.
- **Routine** - Within 45 calendar days of the request.
- **Routine for DCS CHP** - Within 30 calendar days of the request. 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

Here are some important notes about dental homes:

- 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. (Mercy Care assigns member to their dental home on enrollment.)
- The AHCCCS Dental Periodicity schedule (AMPM 431-Attachment A) must be followed and recommends that members make their first dental appointment by age one and every six months thereafter.
- The dental home should provide:
  - Comprehensive oral health care including acute care, preventative care, and a comprehensive assessment for oral diseases and conditions.
  - Individualized preventive dental health program based upon a caries-risk assessment and a periodontal disease risk assessment.
  - Anticipatory guidance about growth and development issues (i.e., teething, digit, or pacifier habits) as well as dietary counseling.
  - Information about proper care of teeth and gums, including the prevention, diagnosis, treatment for disease of the supporting and surrounding tissues; and the maintenance of health, function and esthetics of those structures and tissues.
  - Plan for acute dental trauma and referrals to dental specialists when care cannot directly be provided within the dental home.

Fluoride Varnish Application by PCP

According to the ADHS 2019-2022 State Oral Health Plan, only 57.8% of Arizonans receive the optimal amount of fluoride through drinking water, compared to the United States average which is 74.7%. In efforts to improve these numbers and to decrease the rate of children with cavities, ADHS and AHCCCS are encouraging PCPs to apply fluoride varnish to children's teeth during their well visit. Application of the fluoride varnish done during a well visit, does not take place of the two fluoride varnish applications done by the dentist during their bi-annual dental visits. PCPs can apply fluoride varnish for a member as early as 6 months of age, with at least 1 tooth eruption, and can be applied every 3 months (4 times a year) after that. These applications can occur up to the members 5th birthday. The additional visits will also be reimbursed according to the AHCCCS-approved fee schedules.

Fluoride varnish training

AHCCCS recommended training for fluoride varnish application. Refer to the training that covers caries-risk assessment, fluoride varnish, and counseling. The trainings can be found on the AAP website: https://www.aap.org/en/patient-care/oral-health/oral-health-education-and-training.

Fluoride varnish coding and claims
The AAP has listed out details on the ICD-10 codes for EPSDT Well Visits and Fluoride Applications by PCP's called the AAP Coding for Pediatric Preventive Care:
https://downloads.aap.org/AAP/PDF/coding_factsheet_oral_health.pdf

CPT: 99188 application of topical fluoride varnish by a physician or other qualified health care professional

Routine Encounter/Screening
Z00.121 Encounter for routine child health examination with abnormal findings (Use additional code to identify abnormal findings, such as dental caries)

Dental Caries Risk (Z91.84 an Z91.849 for use with CPT 99188 only)
Z91.84- Risk for dental caries, low, moderate, or high 6th digit required
Z91.849 Unspecified risk for dental caries
Z00.129 Encounter for routine child health examination without abnormal findings
Z13.84 Encounter for screening for dental disorders
Z29.3 Encounter for prophylactic fluoride administration (fluoride varnish)

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/Oral Health Resources

- **ADHS 2019-2022 State Oral Health Plan**
- **National Maternal and Child Oral Health Resources Center**
- **AMPM 431 - EPSDT Dental Policy**
- **AMPM 431 - EPSDT Dental Periodicity Schedule**
- **DentaQuest (Mercy Care's Delegated Dental Vendor)**

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 Maker (HCDM), Designated Representative (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.

431 – Attachment A - Page 1 of 1

Effective Dates: 10/01/18, 10/01/19, 02/01/21, 10/01/22, 10/01/23
Approval Dates: 06/07/18, 05/30/19, 11/06/20, 04/21/22, 06/13/23

Source: https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/400/431_AttachmentA.pdf

Monitoring BMI

Body Mass Index (BMI) is used to assess adequate weight gain, underweight, overweight, and at risk for becoming overweight. Children's body size changes over the years as they grow. Also, girls and boys differ in their body fat distribution as they mature. For that reason, BMI percentile for children is measured by age and gender. BMI percentiles 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:

- Education on 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.

EPSDT providers must notate the members weight, height, and BMI percentile on the members submitted EPSDT form or submitted electronic medical record. Providers should also notate if nutritional education or referrals have taken place or if the member is already receiving WIC services. This information is used for our educational mailings as well as regulator reports.

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
- 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: Resource 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

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

- American Academy of Pediatrics (AAP): Clinical Practice Guideline for Obesity
- 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 FAQs: https://www.cdc.gov/bmi/faq/?CDC_AAref_Val=https://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 well visit and on an inter-periodic basis if the PCP feels it is necessary.
- 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 or nutritionist in Mercy Care's network, including our overweight and underweight members.
- Members in need of nutritional therapy due to a medical condition and if the medically necessary formula is exempt from WIC, then they may be referred to Aveanna Healthcare; Mercy Care's contracted DME provider for these services.
- Any members in need of infant formula that are not medically necessary or WIC-exempt, should be referred to WIC.
- 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). Documentation must demonstrate that the member meets all of the required criteria and meets medical necessity on an individual basis.
- For initial requests, documentation should show nutritional counseling has taken place, visit notes are within three months of the request, all previous and current measurements and BMI percentiles (or weight-for-length), and any alternative treatments that have been tried and failed.
- For ongoing requests, notes should be within three months of the request and show the members overall response to their current nutritional therapy regime, including tolerance, hospitalizations, measurements, and BMI percentiles (or weight-for-length).
- For members receiving nutritional therapy, providers must physically assess the member at least

annually. Documentation should include provider encouragement in attempting to wean the member off nutritional therapy, if appropriate.

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

If an AHCCCS covered member has a congenital metabolic disorder identified through the Bloodspot Newborn Screening Panel, then medical foods are covered as specified in A.R.S. § 20-2327. Refer to AHCCCS Medical Policy Manual, (AMPM), Policy 310-GG for more details and limitations.

TB Monitoring & Testing Requirements

- Providers must have a process to encourage their patients to return for a timely reading of their Tuberculin (TB) skin test, to ensure their patients receive timely care if it is needed.
- Providers should coordinate care with Mercy Care as well as any servicing facility that the member may utilize for testing and treatment.
- TB skin testing should be performed as appropriate to age and risk, for members between 12 months old and up to 21 years old. Members at increased risk of tuberculosis (TB) include those who have contact with persons:
  - Confirmed or suspected of having 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/immigrating 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, caregiver occupation, cooking utensils brought from another country, and hobbies.

- **All children 6 months to 6 years old** are recommended to have a **verbal lead screening** completed at each well visit. During those visits, providers should provide anticipatory guidance on lead safe environments. Providers can also use the ADHS Parent Questionnaire during these screenings. 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 6 years of age who have not been previously tested, or who missed either the **12 month or 24 months test, must have a blood lead test.**
- In accordance with AMPM 430, 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 known risk-factors.

Blood Lead Testing Recommended Schedule

Since 2021, 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

Provider Requirements for Elevated Blood Lead Levels (EBLL)

- According to A.A.C. R9-4-302, Providers must report elevated blood lead levels to the Arizona Department of Health Services (ADHS) to ensure timely follow-up and retesting.
- Providers will use the Provider Report Form and submit EBLL (per CDC reference values) and submit the completed form to ADHS via fax at **602-364-3146**.
- Providers must report to ADHS all EBLL levels between **3.5-10 µg/dL within a month, between 10-45 µg/dL within 5 days, and over 45 µg/dL within 1 day**.
- Providers will also report non-elevated results to ADHS for children that had a previous EBLL, to assist in ADHS follow-up.
- For members with an EBLL, providers should assist in coordinating care to ensure timely follow-up and retesting.
- In the event a member with EBLL loses AHCCCS eligibility or is transferred from one plan to another, providers should help them navigate the healthcare system by referring them to low-cost or no-cost follow-up testing and treatment centers..

Blood Lead Level Testing Resources

- CDC: Blood Lead Surveillance Data
- CDC: Testing for Lead Poisoning
- CDC: Recommended Actions Based on Blood Lead Level
- CDC: Recommended Terminology When Discussing Children's Blood Lead Levels
- CDC: Childhood Lead Poisoning Prevention
- ADHS: Risk Assessment Parent Questionnaire
- ADHS: List of High-Risk Zip Codes
- ADHS: Find My Zip Code on a Map
- ADHS Lead Poisoning
- ADHS: Recommendations on Blood Lead Testing for Refugees

AzEIP

The Arizona Early Intervention Program (AzEIP) is an early intervention program that offers a statewide system of support and services for infants and toddlers between birth through 36 months old (three years of age) who have a significant developmental delay (at least two standard deviations, approximately 50%, below the mean) in one or more areas of development or has been diagnosed with a condition that has a high probability of resulting in a developmental delay. 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 and care coordination under Sec. 1905 [42 U.S.C 1396d]. Mercy Care may receive notice of concerns about a child's development that is initially identified by the child's PCP, Caregiver, Care Manager, Case Manager, or by AzEIP. Mercy Care then 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 through fax # **959-900-6387** or via email MCAzEIP@mercycareaz.org.

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 the process 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 case management, 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.

Important Notes:

- **PCP's must submit an AzEIP referral within 7 calendar days of identification of a child with suspected developmental delay or disability that results in a delay.**
- **PCPs must return the signed AMSR form (AMPM 430 - Attachment D) to the Mercy Care AzEIP Coordinator within 10 business days to ensure there is no delay in care for the member.**
- Providers (PCPs or servicing providers) MUST communicate to the plan the results of any AzEIP assessments and/or therapies provided to AzEIP enrollees **within 45 days of the therapy date listed in the Individual Family Service Plan (IFSP)**.
- IFSPs can be noted as an **initial referral or a redetermination that can be done every 3 months, 6 months, or annually. For DD and ALTCS members, the IFSP is to be reviewed every 90 days**. IFSPs are also reviewed if any changes are made to the service request. Any changes to services must be reviewed by the PCP for medical necessity.
- All AzEIP IFSP requests must be reviewed by the PCP for medical necessity prior to approving the prior authorization and providing service provider reimbursement.
- If the member is already getting services through a non-contracted AzEIP provider, Mercy Care will continue to approve those services if they are medically necessary and should not deny the services based on network status.
- AzEIP therapy services will continue to be provided until the PCP or servicing provider determines the services to be no longer medically necessary.
- Members that have aged out of AzEIP **(ages above 2 years-9 months old)** and have not initiated services yet, Mercy Care may assign them to a contracted provider to maintain continuity of care while AzEIP begins the aging out process.
- Members that are aging out of AzEIP should be enrolled in their school program. This process is initiated by the AzEIP Service Coordinator. The provider can also request additional therapy services through the regular prior authorization process if they deem it to be medically necessary.

AzEIP PCP Initiated Service Requests

- During the well visit the PCP will determine the child's developmental status through discussion with the family/parents/guardian using the completed developmental screening.
- When the PCP identifies a child with a significant developmental delay or has been diagnosed with a condition that has a high probability of resulting in a developmental delay and the PCP believes the member will benefit from receiving therapies, then the PCP will request an AzEIP evaluation (referral).
- *Mercy Care asks that providers request an AzEIP therapy prior authorization, even if the CPT Codes are NO PA.*
- **PCP's must submit an AzEIP referral within 7 calendar days** of identification of a child with suspected developmental delay or disability that results in a delay.
- PCP's can refer a member to AzEIP by submitting the application in the AzEIP Referral Portal, by notating the referral on the EPSDT Form, or by faxing the referral using the AzEIP Fax line.
- **Mercy Care prefers that PCPs utilize the Mercy Care AzEIP Fax line as it helps the Mercy Care AzEIP**

Department to coordinate care for the member.
  - Referrals received through the AzEIP Fax # 959-900-6387 will be processed as soon as possible.

- When using the EPSDT form or electronic medical record (EMR), it is important for providers to mention the AzEIP referral and type of therapy needed as these details are used for reporting. Also, by notating this referral on the EPSDT Form, it triggers a letter to the member informing them about the program.
- Submitting the members EPSDT Form/EMR in a timely manner helps to avoid any delay in care.
- Once a referral is received, the MC AzEIP Coordinator then researches to see if the member has a case manager/care manager or is ALTCS or DCS CHP. If they do, then the MC AzEIP Coordinator will involve them to help coordinate care.

Processing the PCP AzEIP Referral

- The MC AzEIP coordinator will begin the AzEIP referral process by entering the member information into the AzEIP Online Portal: https://azeip.azdes.gov/AzEIP/AzeipRef/Forms/Categories.aspx.
  - AzEIP then reviews all submitted documentation following the timelines outlined in AMPM 430 - Attachment C to determine AzEIP eligibility.
  - Once the member is entered into the AzEIP system, the AzEIP Service Coordinator then sends an email to the MC AzEIP Coordinator informing them of the members assigned AzEIP region.
  - *If the AzEIP Service Coordinator informs Mercy Care that the member is not eligible,* then the MC AzEIP Coordinator will coordinate with the PCP, the care manager/case manager, and/or the parents/guardians/caregivers to assist members in finding a therapist that can help their child and help in setting appointments. (Note: Currently, no PA is needed for non-AzEIP therapy visits.)
  - *If the member is eligible,* the AzEIP Service Coordinator will follow the IFSP process outlined in the AzEIP Policy and Procedure Manuals. The MC AzEIP Coordinator will monitor communications to see if an IFSP is received. If the IFSP documents are not received within 45 days, then the request will be considered closed.

PCP Prior Authorization (PA)

- If the provider requests a prior authorization (PA) at the same time as the AzEIP referral, then the PA will follow the normal PA timelines.
  - *Mercy Care will not delay or postpone the initiation of medically necessary EPSDT services while waiting on AzEIP eligibility determination or the IFSP process.*
  - *Mercy Care may do an extension or a denial of* the PA request if there will be a delay in completing the AzEIP evaluation, if the PCP needs more time to schedule additional visits with the child to evaluate medical necessity, or if the plan requires additional documentation in order to approve the request.
  - *If Mercy Care denies the request,* it would follow the denial steps listed below and if needed, the AzEIP referral can then be resubmitted.
- Once the PA request is approved or denied, the final decision will be sent to the PCP and to AzEIP.
  - *If the PA is approved,* the approval fax will be sent to the PCP, the servicing provider, and the AzEIP Service Coordinator. AzEIP will continue reviewing the enrollment process (IFSP) and their process will follow the steps in the "AzEIP Initiated Service Request" section.
  - *If the PA is possibly going to be denied, reduced, or suspended,* the MC AzEIP Coordinator will attempt to coordinate with Mercy Care Medical Directors, the PCP and/or the members care manager/case manager to try and get the request approved. The goal for Mercy Care is to approve these therapy services if possible.
  - *If the PA is denied, reduced, or suspended,* the MC AzEIP Coordinator will inform the AzEIP Service

Coordinator, the servicing facility, and the PCP. The MC AzEIP Coordinator will then contact the PCP, the care manager/ case manager, and/or the parents/guardians/caregivers to assist members in finding a therapist that can help their child and help in setting appointments. (Note: Currently, no PA is needed for **non-AzEIP** therapy visits.)

AzEIP Initiated Service Requests

Once an EPSDT child is referred to AzEIP, AzEIP screens all documentation and meets with the family/caregivers. AzEIP will obtain parental consent to request and release records to/from the child's PCP. AzEIP will then conduct an evaluation to determine the child's eligibility for AzEIP and if appropriate, they will complete an Individual Family Service Plan (IFSP). The AzEIP Service Coordinator then sends the completed IFSP, the completed AzEIP AHCCCS Member Service Request Form (AMSR) (AMPM 430-Attachment D), and any evaluations or assessments to the MC AzEIP Coordinator. AzEIP will follow the required timelines outlined in AMPM 430 – Attachment C as well as the in the AzEIP Policy and Procedure Manuals.

Mercy Care's Process

- Once the MC AzEIP Coordinator receives the request from AzEIP, they will research to see if the member has a case manager/care manager or is ALTCS or DCS CHP. If they do, then they will involve them to help coordinate care.
- The MC AzEIP Coordinator then faxes all documentation (IFSP, AMSR form, and any evaluations or assessments for that member) to the PCP to review for medically necessity.
- Once the MC AzEIP Coordinator receives the signed AMSR form from the PCP, they will complete the request based on the PCP's response:
  - *If the PCP approves the request*
    - **The PCP indicates on the AMSR form (AMPM 430-Attachment D) that the services are medically necessary, adds the diagnosis if it was not supplied, signs and dates the form and faxes the AMSR form back to the MC AzEIP Coordinator within 10 calendar days of receiving it via the AzEIP Fax # 959-900-6387.**
    - The Provider does not need to send all documents back to Mercy Care. Only the signed AMSR is needed.
    - The MC AzEIP Coordinator will approve the PA for therapy services.
    - The PA approval is faxed to the PCP, servicing facility, and the AzEIP Service Coordinator.
    - The MC AzEIP Coordinator then completes the Mercy Care portion of the AMSR form (AMPM 430-Attachment D) and faxes the completed form back to the PCP, the servicing facility, and the AzEIP Service Coordinator.
  - *If the PCP decides that the services are not medically necessary, or if the PCP wants to examine the member to determine medical necessity*
    - **The PCP indicates on the AMSR form (AMPM 430-Attachment D) that the services are not approved (including the reason why), adds the diagnosis if it was not supplied, signs and dates the form and faxes it back to the MC AzEIP Coordinator within 10 calendar days of receiving it via the AzEIP Fax # 959-900-6387.**
    - The MC AzEIP Coordinator will deny the PA therapy request per the PCP decision.
    - The Notice of Action (NOA) team and/or the MC AzEIP Coordinator sends the denial to the parent/guardian/caregiver, the PCP, the servicing facility, and the AzEIP Service Coordinator.
    - The MC AzEIP Coordinator completes the Mercy Care portion of the AMSR form (AMPM 430-Attachment D) notating the request was denied and notates that the NOA was

completed and faxes the completed AMSR form back to the AzEIP Service Coordinator.
  - The MC AzEIP Coordinator will then contact the PCP, the case manager/care manager, and/ or the parents/guardians/caregivers to assist members in setting appointments or in finding a way to get the member the services they need. (Note: Currently, no PA is needed for **non-AzEIP** therapy 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
- AzEIP Policies and Procedures

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

Developmental Surveillance

Developmental surveillance should be part of every well visit, and if concerns are noted, further screenings and/or referrals would be indicated. If treatment is required, then it shall occur on a timely basis, generally initiating services no longer than 60 days beyond the request/referral for screening services. Be sure to monitor the CDC and American Academy of Pediatrics (AAP) as they regularly update and revise development milestones through the "Learning the Signs. Act Early." program. Providers must utilize the most up to date developmental milestone tools available.

Developmental Screening

In addition to developmental surveillance, developmental screenings must also be completed. Developmental screenings can be done during any well visit, but providers must complete the screenings on the specific well visit dates that are listed in the EPSDT Periodicity Schedule.

Example of screenings done on specific dates:

- Global developmental screenings are required at the 9-month, 18 month and 30-month visits.
- Domain Specific Screenings, such as Autism Specific Developmental (ASD) Screenings are required during the 18 month and 24-month visits.

EPSDT providers must use the most up to date developmental screening tools which can be found on the American Academy of Pediatrics (AAP) and Bright Futures website. Providers shall be trained in the use and scoring of these tools, as indicated by the AAP. **The developmental screening tool that was used must be saved in the member's medical record.** The members medical record and any submitted EPSDT Forms should notate which tool that was used, the score that was received, if a referral was made, and if any counseling has taken place. If the member has an abnormal finding, or if there are any concerns, then the provider should create a referral for that member. Referrals must be done in a timely manner. After a referral is made, providers must also follow up with the member or the servicing provider to make sure the referral appointment has been set or has taken place *no longer than 60 days from the date of the referral*.

Below are a couple examples of accepted Global Developmental Screening Tools:

- The Parents' Evaluation of Developmental Status (PEDS-R)- Age range: Birth to 8 years of age.
  - www.pedstest.com or https://pedstestonline.com/
- Ages and Stages Questionnaires™ Third Edition (ASQ-3)- Age range: Birth to 5 years of age.
  - www.agesandstages.com

Below are a couple examples of accepted Domain Specific Developmental Screening Tools:

- Ages and Stages Questionnaires®: Social-Emotional (ASQ:SE) is a tool which is used to identify delays or concerns for a child's social-emotional wellness. Age Range: up through 21 years old.
  - www.agesandstages.com
- Modified Checklist for Autism in Toddlers (M-CHAT-R/F) is a tool which is used to identify delays and any concerns autism. Age range: 15 to 30 months.
  - https://www.mchatscreen.com/

For purposes of the EPSDT program, screenings are not synonymous with diagnosis.

Developmental Screening Claims

As of January 2024, all Medicaid primary care providers are required to follow the CMS and Medicaid Core Measures as these measures are focused on improving quality care nationwide. The CMS Child Core Set provides a description of the required visits, testing, screenings, and coding providers should be utilizing. In November 2023, AHCCCS began updating their EPSDT WCV and Developmental Screening Coding Process to align with the requirements that were being released in the 2024 CMS Core Measure- Developmental Screening in the First Three Years of Life.

Claim Requirements:

- Prior to providing the service, the provider must complete the required training for the developmental screening tool being utilized.
- Copies of the completed training documents must be retained in the member's medical record.
- Copies of the completed training documents must be saved into the CAQH. *Note: CAQH is not only used for claims. It is also used by the EPSDT Coordinators for our provider documentation audits.*

- *For the Global Developmental Screening well visit*
  - Well Visit: 9-, 18-, and 30-months visit
  - CPT/Modifier: 96110-EP
  - ICD-10: Z13.42
- *For the Domain-Specific Developmental Screening well visit (i.e., ASD Screening)*
  - Well Visit: 18- and 24-months visit
  - CPT/Modifier: 96110-EP
  - ICD-10: **DO NOT use Z13.42 for the domain-specific screenings.**

Note: The 18-month well visit is the only visit where the 96110-EP code can be used twice in the same visit. This is because both the Global and ASD Screenings are required during that visit.

AHCCCS Updated Coding Process - can be found on the AHCCCS website under - Plans & Providers - Medical Coding Resources - AMPM 430 EPSDT Service Codes Document - Updated 11/20/23.

More information on the 2024 and 2025 CMS and Medicaid Child Core Set is available on Medicaid.gov at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-coreset/index.html

Legislation making reporting of the Child Core Set measures mandatory as of January 2024, in Section 50102(b) of the Bipartisan Budget Act of 2018. The legislation can be found here: https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.xml

Developmental Screening Resources

Additional websites/resources that can be helpful and educational:

- CDC “Act Early” Developmental Screening website
- CDC “Act Early” Brief Checklist of Developmental Milestones
- CDC “Act Early” Developmental Monitoring and Screening Fact Sheet
- CDC/AAP “Learn the Signs. Act Early.”
- AAP Bright Futures
- AAP Bright Futures Toolkit - Screening and Assessment Forms
- AAP Screening Tool Finder
- Birth to 5: Watch Me Thrive!

EPSDT Provider Audits – Screenings, Trainings, and Documentation

To ensure our members are receiving the care they need, Mercy Care will be conducting quarterly provider audits on completed behavioral health screenings, developmental screenings, and fluoride varnish applications. The provider selection for the audit is random, and if selected, we will be requesting medical records. If trainings are required for any of the tools used, then we will also be reviewing the training documents you have saved in the CAQH. All EPSDT/MCH completed training tools must be saved to CAQH, regardless of the credentialing process. We will also be noting if the screening was completed at the appropriate date/time.

Developmental Screening Trainings

Per AHCCCS AMPM 430, providers that bill for behavioral health screenings must be trained in the use and scoring of those developmental screening tools as indicated by the American Academy of Pediatrics (AAP). The 2024/2025 CMS Core Set Measures, the AAP, and the Bright Futures websites provide lists of approved and verified tools/trainings. To assist us with the audit process, a copy of the completed training documents must be

saved in the CAQH. During the audit we will be looking for the use of a validated screening tool, if the training was completed prior to use, if the tool is saved in the members medical record, the score received, if any counseling/discussion has taken place, if a referral was needed, if the referral was done in a timely manner, and if the provider followed up on that referral to ensure the visit has taken place.

Listed below are a few developmental screening tools that require trainings:

- Parent's Evaluation of Developmental Status-Revised (PEDS-R)
- Ages and Stages Questionnaire, Third Edition (ASQ-3)
- Ages and Stages Questionnaire, Social-Emotional (ASQ-SE)
- Modified Checklist for Autism in Toddlers, Revised with Follow Up (M-CHAT-R/F)

Fluoride Varnish Application Trainings

Per AHCCCS AMPM 431, providers are required to complete a training for applying fluoride varnish. The document showing the provider has completed the fluoride varnish training will be used in Mercy Care's credentialing process for reimbursement, as well as for our quarterly provider audits. The EPSDT/MCH Department uses the CAQH database for these audits. The screening tools that can be used can be found on the AAP website: https://www.aap.org/en/patient-care/oral-health/oral-health-education-and-training/

Behavioral Health Screenings

Per AHCCCS AMPM 430, in addition to the required screenings listed above, there are additional behavioral health screenings that providers must complete during certain well visits. During the audit we will be looking for the use of a validated screening tool, if the tool is saved in the members medical record, the score received, if any counseling/discussion has taken place, if a referral was needed, if the referral was done in a timely manner, and if the provider followed up on that referral to ensure the visit has taken place. Listed below are a few validated screening tools that can be used:

- Maternal PPD Screening- Patient Health Questionnaires (PHQs) PHQ-9
- Adolescent Suicide Screening- PHQ-9 Modified for Teens (PHQ-A)
- Adolescent SUD Screening – Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT)

Note: For more details on the well visit dates, requirements, and additional tools that are available, refer to these sections within this Provider Outreach Manual:

- AHCCCS EPSDT Periodicity Schedule
- Adolescent Suicide and Depression Screening
- Perinatal Mood and Anxiety Disorder Screening of the Birthing Parent
- Addressing Perinatal Mood Disorders and Anxiety

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/

Behavioral Health Screenings, Referrals and Follow up Requirements

PCPs can 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 coordinate with a behavioral health provider to ensure the member receives care. Coordination may include a referral and/or transition of care to a behavioral health provider. Coordination of care for behavioral health services must be completed in a timely manner. If treatment is required, then initiating services should occur no longer than 60 days beyond the date of the request/referral. PCPs are required to follow up on all referrals to ensure the visit has taken place.

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 treated by a PCP: ADHD, depression, anxiety, tobacco cessation, etc.
- The member requires services outside the PCP's scope of expertise.
- 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.

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

American Academy of Family Physicians also has tools and guidance on mental and behavioral health. You can find them here: https://www.aafp.org/family-physician/patient-care/clinical-recommendations/clinical-guidance-mental-and-behavioral-health.html#Treatment

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 the members basic behavioral health information and their needs 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 behavioral health 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 physical health status changes, their medication changes, or any new medications have been prescribed.

Behavioral Health Serious Mental Illness (SMI) Referrals

Mercy Care ACC-RBHA covers Maricopa County, Pinal County, and Gila County for members 18 years of age or older with a serious mental illness (SMI) designation. **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 Members with a SMI Designation Member Services: **602-586-1841 or 1-800-564-5465**
Mercy Care ACC-RBHA with a SMI Designation Referral Fax # **844-424-3975**

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

- Phone line 602-222-9444
- Toll free 800-631-1314 or TTY 800-327-9254

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

Arizona Pediatric Psychiatry Access Line (Pediatric A-PAL)

The University of Arizona created a behavioral health hotline for primary care providers to help reduce mental illness and mortality in child and adolescent populations by guiding frontline health care providers in pediatric psychiatric management.

Providers have real-time access to pediatric psychiatrists via the Pediatric A-PAL Hotline. This is a free service for medical providers. Providers can use this phone line to ask questions and review treatment options for their child and adolescent patients with behavioral health concerns. The hours of operation are Mon-Fri 8:30 a.m.-4:30 p.m.
Phone: 888-290-1336
Website: https://apal.arizona.edu/pediatric

AHCCCS Navigating the Behavioral Healthcare 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.

Source: https://www.azahcccs.gov/Members/Downloads/AccessingBHSystem.pdf

Behavioral Healthcare 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

Source: https://www.azahcccs.gov/Members/Downloads/AccessingBHSystem.pdf

Adolescent Suicide and Depression Screening

Suicide is a serious public health problem that can have lasting harmful effects on individuals, families, and communities. In response to this concern, the Arizona Department of Health Services (ADHS) created the Arizona Suicide Prevention Action Plan 2024-2026. ADHS reported that in 2022, Arizona had 1596 suicide deaths with 201 being under 24 years old and in 2023 there were 1,494 suicide deaths with 171 being under 24 years old. ADHS also reported that the top three methods are firearms, suffocation, and poisoning. Together we can help to prevent suicide by providing education and raising awareness on the available behavior health and crisis resources such as the AHCCCS Behavioral Health System Resource pages above, the multiple suicide prevention links provided below, as well as requesting that providers screen their adolescent patients for Suicide and Depression during their well visits.

AHCCCS requires providers to do Adolescent Suicide and Depression screenings for all individuals at each of their well visits from age 10-20 years old. Providers must use a standardized, norm-referenced screening tool specific for suicide and depression. *The screening 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. Providers must also follow up with the behavioral health provider to ensure their first visit has taken place. Providers shall continue to coordinate with the behavioral health provider to inform them of any changes in the members medical condition or medications.

An example of an approved validated screening tool is the Adolescent Suicide Screening - PHQ-9 Modified for Teens (PHQ-A).

Adolescent Substance Use Disorder (SUD) Screening

Per the Centers for Disease Control and Prevention (CDC), 15% of high school students have tried some type of illicit or illegal drug and 14% have misused prescription opioids. The goal for Mercy Care and our providers is to work together to prevent the youth in Arizona from engaging in these risky behaviors. Screening adolescents for substance use disorders (SUDs) helps reduce their risk for adverse outcomes such as injury, overdose, dropping out of school, or getting in trouble with the law. Screening adolescents for SUD also helps us provide support for that child if it is needed.

Providers MUST perform the AHCCCS required Adolescent Substance Use Disorder (SUD) Screening for all individuals at each of their well visits from ages 12 to 20 years old. Providers must use a standardized, norm-referenced screening tool specific to Adolescent SUD. *The screening 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. Providers must also follow up with the behavioral health provider to ensure their first visit has taken place. Providers shall continue to coordinate with the behavioral health provider to inform them of any changes in the members medical condition or medications.

An example of an approved validated screening tool is the Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) Screening.

For a list of approved screening tools for Adolescent Suicide and Depression and Adolescent SUD, you can visit the AAP Bright Futures Toolkit website: https://publications.aap.org/toolkits/resources/15625/

Note: For EPSDT Form submissions, providers must mention the screening tool that was used (even if there is not a selection for it on the pre-printed EPSDT Forms), the score that was received, if counseling was done, and what referrals were made.

SUD Data Source: https://www.cdc.gov/healthyyouth/substance-use/index.htm

Suicide Prevention and SUD Screening Resources

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

- ADHS Arizona Suicide Prevention
- ADHS Arizona Suicide Prevention Action Plan 2024-2026
- ADHS Real Time Suicide Data
- CDC Suicide Prevention Resources 2022
- Lifeline (provides, free and confidential support 24/7)
- NIH Screening for Substance Use in the Pediatric/Adolescent Medicine Setting
- SAMHSA Advisory: Screening Adolescents for SUD
- SAMHSA Prevention of Substance Use and Mental Disorders
- SAMHSA - Screening and Assessing Adolescents for SUD
- AAP Preventative Care/Periodicity Schedule
- AAP Practice Resource Toolkit 2nd Edition – Mental Health Tools for Pediatrics

Suicide Prevention Hotlines

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

Perinatal Mood and Anxiety Disorder (PMAD) Screening of the Birthing Parent

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 perinatal mood and anxiety disorder.

Providers must perform the AHCCCS required perinatal mood and anxiety disorder screening for the birth parent at the 1 month, 2-month, 4-month, and 6-month well visits. Providers must use a standardized, norm-referenced screening tool specifically looking for perinatal mood and anxiety disorder. *The tool must be saved in the member's medical record.* Positive results must be referred in a timely manner to the birthing parents health plan and their appropriate case manager. Providers should also follow up on that referral to ensure their first visit has taken place.

Note: For more details on the screening requirements and a list of additional validated screening tools, refer to the Maternity section in this manual: *Addressing Perinatal Mood Disorders and Anxiety*.

These adolescent and birthing parent screening requirements are outlined in AMPM 430 EPSDT Policy and in the AMPM 430-Attachment A: EPSDT Periodicity Schedule. **You can find additional details on the Well Visit Required**

Screening CPT codes as well as the required modifier details in the AMPM 430 EPSDT Service Codes Document - Updated 11/20/23. This document can be found on the AHCCCS website under - Plans & Providers - Medical Coding Resources.

Perinatal Mood and Anxiety Disorder (PMAD) Educational Resources

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

Perinatal Mood and Anxiety Disorder (PMAD) Resources

- Postpartum Support International (PSI): Information, education, and support for parents, support systems, and professionals.
- CDC HEAR HER Campaign: Information on Urgent Maternal Warning Signs and 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 childcare 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 Policy Ch 581 – Working with the Birth Through Five Population for additional information on behavioral health screening, assessment, and treatment 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 AHCCCS 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 well visits and submit the results to Mercy Care using either 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 EPSDT Periodicity Schedule

AHCCCS
Arizona Health Care Cost Containment System

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 – Primary Care Physician (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 mother/parent			x	x	x	x																								
Adolescent Suicide Screening																				x	x	x	x	x	x	x	x	x	x	x
Adolescent Substance Use Disorder Screening																						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

430 - Attachment A - Page 1 of 4

Effective Dates: 03/01/19, 05/07/19, 03/01/19, 02/01/22, 10/01/22, 11/28/23

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, 08/17/23

Source: https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/400/430_AttachmentA.docx

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
Newborn Metabolic Screening[2]	←	x	→	→																										
Immunizations	SEE CENTERS FOR DISEASE CONTROL AND PREVENTION WEBSITE																													
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 Policy 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 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visit for children who have reached six months of age with at least one tooth erupted, with recurrent applications up to five 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.

430 - Attachment A - Page 2 of 4

Effective Dates: 03/01/19, 05/07/19, 03/01/19, 02/01/22, 10/01/22, 11/28/23

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, 08/17/23

Source: https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/400/430_AttachmentA.docx

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

<u>These are minimum requirements</u>: **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

<u>These are minimum requirements</u>: **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.**

430 - Attachment A - Page 4 of 4

Effective Dates: 03/01/19, 05/07/19, 03/01/20, 02/01/22, 10/01/22, 11/28/23
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, 08/17/23

Source: https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/400/430_AttachmentA.docx

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** years old but it can be given to members up through the age of 45. (Note: After age 15 it increases from 2 shots to 3 shots.)

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 (2024) - Printable: Birth to 18 years old
- CDC - Pregnancy and Vaccines
- CDC - Parents Who Question Vaccines
- CDC - Vaccine Educational Resources 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
- TAPI - Resource Materials for Providers

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 additional medical 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

CDC 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
(ASSIIS): 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://redcapaipo.azdhs.gov/surveys/?s=KJ38PFT994EMT7EE

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. Be sure to monitor the ADHS VFC Program website for any updates.

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.

- **AHCCCS Providers must maintain the ASIIS immunization records of each EPSDT member up through age 18 years old in ASIIS, in accordance with A.R.S. Title 36, Section 135.**
- Providers must also document immunizations in ASIIS for members who are 19 and 20 year of age.
- **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. For additional links on ASIIS and the VFC program, please see the ADHS VFC website.

VFC *2024 Update*

- VFC Program Summary of Policy Changes June 2024
- Arizona VFC Program Operations Guide June 2024

Incident Report *2024 Update*

- Provider Contacts the Manufacturer(s)
  - Temperature Incident Instructions & Checklist
  - Vaccine Incident - Provider Process
- BIZS Contacts the Manufacturers
  - Vaccine Incident - BIZS Process

Required Forms *2024 Update*

- Borrowing Report and Instructions
- Temperature Logs
- Vaccine Accountability and Management Plan
- Wasted/Expired Vaccine Return Form
- ASIIS Provider Profile Change Form

Fillable PDF Vaccine Records Forms *2024 Update*

- Adult Immunization Administration Record (AIR111-2) Black and White Version
- Childhood-Adolescent Immunization Administration Record (AIR111-1) Black and White Version
- Influenza Administration Record (AIR111-3) Black and White Version

Eligibility

- Patient Eligibility Screening Record - VFC English
- Patient Eligibility Screening Record - VFC Spanish
- VFC and Insurance Billing Guidance

Resources

- Temporary, Mobile, Off-Site, or Satellite Clinics for VFC Providers
- Hourly Vaccine Temperature Log for Outbreak Response *2024 Updated*
- Defrosting Your Manual VFC Freezer
- 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
- CDC Vaccine Storage and Handling Toolkit *2024 Update*
- Eligible Vaccinators in Arizona *2024 Update*
-

Job Aids

- 2024-2025 Pediatric Influenza Vaccines *2024 Update*
- 2024 AAP Parent Vaccine Refusal Form *2024 Update*
- Immunization Form Order Request *2024 Update*
- Deputized Provider List (Rural and County Health Dept Locations) for Underinsured Referrals
- Are You a New Primary/Backup VFC Vaccine Coordinator?
- CDC's You Call the Shots Webinar and Certificate Instructions
- Inactivation Form
- Inactivation Checklist - VFC
- Vaccine Adverse Event System (VAERS) Form
- Adolescent Meningococcal Presentations
- VFC New Facility/Change in Ownership or New Electronic Medical Records Checklist *2024 Update*

ASIIS

- How to Add-Edit Physicians and Vaccinators in ASIIS
- Ensure Your Office Submits Quality Data to ASIIS
- How to Log into ASIIS
- How to Search-Add-Edit a Patient Record in ASIIS
- How to Inactivate Patients in ASIIS

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 17,000 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 a 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 submit a completed EPSDT form, even if the patient schedules an appointment for something else.
- Complete a Provider Missed Appointment Log or 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.

Mercy Care website: www.MercyCareAZ.org
Department of Economic Security - DDD: https://des.az.gov/services/disabilities/developmental-disabilities
Email: **DDDCustomerServiceCenter@azdes.gov**
Phone: **1-844-770-9500 (TTY 711)**
Fax: **602-542-6870**

DDD Medical Benefits

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** (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 (plan year is October 1-September 31).

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.

These dental limits do not apply to American Indian/Alaska Native (AI/AN) members when getting dental services at an Indian Health Services (IHS/638) facility.

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 active treatment.

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.

Can members 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.

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).

mercy care

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 EPSDT form for that well visit, as well as notating it in the member's medical record.

DCS CHP – Appointment Timeframes

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 in process of being removed from their home must:

- Be seen by an EPSDT provider for a medical exam within 30 days of placement in out-of-home care and annually thereafter.
- Receive a dental assessment within 30 days of placement for children ages one year and older, and semi-annually thereafter.
- Receive a rapid response appointment, meaning they must be seen by a behavioral health specialist once they enter their out-of-home placement or no later than 72 hours after notification from DCS that the child has been or will be removed from the home.

If members has not been seen within these timeframes 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.

DCS CHP – Mercy Care Outreach and Coordination of Care

Mercy Care EPSDT/MCH Prevention and Wellness Outreach Coordinators or Call Staff as well as our DCS CHP 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 well 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**
- AHCCCS Resources: Foster/Kinship/Adoptive Families
- 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**

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 and anxiety 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 (STI) screening, counseling, and treatment
        a. Annual syphilis testing begins at age 15 years old.
    VIII. Human Immunodeficiency Virus (HIV) screening, counseling, and treatment
    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.

Note: If a member is not able to make it to their appointments, be sure to address any barriers to care the member may be experiencing. Providers can also share this information with Mercy Care so we can provide additional outreach.

Mercy Care Can Help Reschedule Missed Women's Wellness Visits

To help address 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 them listing the date and time of the appointment.
- If the patient misses an appointment, notify the EPSDT/MCH Department and our outreach staff will contact the member by letter and phone to assist them in rescheduling their appointment. During the phone call, the member will also receive education on the importance of showing up for scheduled appointments.
    - Providers can notify the EPSDT/MCH Department by completing the **EPSDT/MCH Missed Appointment Log and faxing it to us.** The log can be found here: Mercy Care Provider Website - Under Provider Forms.

Testing for Sexually Transmitted Infections (STIs)

Arizona has seen a rise in sexually transmitted infections (STIs) in recent years, especially with syphilis and congenital syphilis. 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. 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.

In 2023, ADHS made some updates to STI testing requirements:

- New Recommendations:
    - **Screen all sexually active people aged 15 to 44 for syphilis annually.**
    - Implement opt-out screening for syphilis people of childbearing capacity/pregnant people treated in the ED, Urgent Care, and other health care and/or outreach settings.
    - Including settings that help people with addiction/substance use disorder.
    - In settings where follow-up is uncertain- use a rapid/point of care test and offer same-day. treatment following a positive result prior to discharge.
- In a correctional setting:
    - Implement opt-out screening for people of childbearing capacity/pregnant people, and people with substance use disorder prior to discharge. Use rapid tests and treat if inmates are released prior to receiving test results and treatment.
    - Including opt-out screening for syphilis in settings for people with addiction/substance use disorder.
- Providers Should Continue:
    - Screen all pregnant women at **first prenatal visit, third trimester, and delivery** for STIs regardless of risk. (**Per the ACOG and AMPM 410: This includes syphilis, HIV, and Hepatitis C**.)
    - Anyone with positive screening results must receive follow up visits and appropriate treatment. Providers unable to provide follow-ups shall refer the person to their PCP.
- Additional Notes:
    - Report new diagnoses of syphilis to the local health department **within five business days.**
    - Encourage patients with primary, secondary, or early syphilis to notify their sex partners, and encourage those partners to seek testing and treatment.
    - Follow the 2021 CDC treatment guidelines.

As of 2024, Per AMPM 411, 420, and 430 - members aged 15 and over shall receive annual syphilis testing. Testing can be done more often than annually and also at a younger age based on risk and provider discretion.

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

- Screening 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)
- Annual syphilis testing for members beginning at 15 years old. Testing can be done more often than annually and also at a younger age based on risk and provider discretion.
- Syphilis testing for pregnant women at their first prenatal visit, during the third trimester of pregnancy, and at the delivery of the baby (Per AMPM 410: Refer to A.R.S. §36-693 and A.A.C. R9-6-381 for Arizona state law regarding serologic testing for syphilis).

The CDC recommends STI screenings for the following:
Providers should 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. **For routine office visits, providers should test anyone with signs and symptoms of infection and anyone with a partner that has recently been diagnosed.**

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 including sexually active women beginning at age 15. • Identifying syphilis before pregnancy can help prevent congenital syphilis.
Pregnant Women	• All pregnant women at the first prenatal visit. Retest at 28 weeks gestation and at delivery if at increased risk due to geography or personal risk. (Arizona is listed as an at-risk state.) • *Arizona requires providers to screen all pregnant women at first prenatal visit, third trimester, and delivery regardless of risk. **
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
Person 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 • *Arizona requires providers to screen HIV positive persons at least annually and every 3-6 months if at increased risk.*

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 at 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 at 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
Person 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	• At least annually for sexually active MSM if HIV status is unknown or negative

Men	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
CDC Screening Recommendations and Treatment Guidelines (Updated March 2024):
https://www.cdc.gov/std/treatment- guidelines/screening-recommendations.htm
CDC County-Level Syphilis Rates: https://www.cdc.gov/nchhstp/syphilis-county-level/?CDC_AAref_Val=https://www.cdc.gov/nchhstp/atlas/syphilis/index.html
ADHS Resource: https://www.azdhs.gov/preparedness/epidemiology-disease-control/disease-integration-services/std-control/congenital-syphilis/index.php#cs-providers

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).

According to the CDC, HPV causes about 36,000 cases of cancer in both men and women every year. These vaccines can help prevent pre-cancers and cancers. **Young adults aged 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 aged 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.

HPV Vaccine Resources:
https://whyimmunize.org/hpv/
https://whyimmunize.org/for-providers/hpv-vaccine-resources/
https://www.cdc.gov/hpv/vaccines/

Cervical Cancer Screening (CCS)

Key Statistics:
The American Cancer Society's estimates for cervical cancer in the United States for 2024 are:
- About 13,820 new cases of invasive cervical cancer will be diagnosed.
- About 4,360 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, the death rate in Black women and Native American women is about 65% higher than in White women.
- 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.
- 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.

Source: https://www.cancer.org/content/dam/CRC/PDF/Public/8599.00.pdf
Source: https://www.cdc.gov/cervical-cancer/screening/

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 2024:

- About 310,720 new cases of invasive breast cancer will be diagnosed in women.
- About 56,500 new cases of ductal carcinoma in situ (DCIS) will be diagnosed.
- About 42,250 women will die from breast cancer.

Who should be screened?
Breast cancer mainly occurs in middle-aged and older women. The US Prevention Task Force and the CDC recommended that women who are 40-74 years old get a mammogram every two years. Mercy Care recommends mammograms occur annually. **Mercy Care pays for annual mammograms for women aged 40 years old and older. These annual mammograms are covered at no cost to the member.**

Women who are 40 years old and older should talk to their provider about getting a mammogram. Providers should also be talking with them about the benefits and risks of these screening tests. Providers may also recommendation different screening tests for women at a higher risk.

Source: https://www.cancer.org/content/dam/CRC/PDF/Public/8577.00.pdf
Source: https://www.cdc.gov/breast-cancer/screening/
US Prevention Task Force: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening

mercy care

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.

The OB provider assignments will allow freedom of choice and will not compromise the continuity of care. Members who transition to a new AHCCCS Contractor or enroll with Mercy Care during their third trimester will be given the opportunity to complete their maternity care with their current AHCCCS registered provider, regardless of contractual status, to ensure continuity of care. 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 AMPM 410.

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

- Follow ACOG standards of care, including use of a standardized medical risk assessment tool and ongoing risk assessment. The comprehensive assessment tool should cover psychosocial, nutritional, medical and educational factors.
- *Member medical records are maintained and document all aspects of maternity care provided.*
- High risk members are referred to a qualified provider and are receiving appropriate care.
- Encourage members to attend all prenatal and postpartum visits according to the timeframes according to the AHCCCS ACOM 417 policy and ACOG timelines:
    - First Trimester – within 14 calendar days of identification
    - Second Trimester – within 7 calendar days of identification
    - Third Trimester – within 3 business days of identification
    - High-Risk Condition – as expeditiously as the member's health condition requires and no later than 3 business days of identification of high-risk by Mercy Care or the maternity care provider
    - Emergency Condition – immediately upon identification
    - Return Visit Frequency:
        - Through 28 weeks – the return visit should be every 4 weeks

    - Between 29-36 weeks – the return visit should be every 2 weeks
    - After 36 weeks – the return visit should be once a week
    - High-Risk condition – the returns visits should be according to the members needs
- Schedule postpartum visits during 3rd trimester or before discharge from hospital. Postpartum visit must be completed within the required time frame, which is between 7 to 12 weeks (or 7 to 84 days) post-delivery.
- Educate members on how to navigate the physical and behavioral healthcare system and address any barriers to care the member may be experiencing. Providers can also share this information with Mercy Care so we can provide additional outreach.
- Ensure all members are educated on warning signs for complications during pregnancy and postpartum, and when to call the doctor.
- Discuss the availability of women's preventive care and family planning services and supplies. Providers should deliver these services when appropriate.
- Educate members about healthy behaviors during pregnancy including the importance of proper nutrition, dangers of lead exposure to the people who are pregnant and their developing babies, 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 Long-Acting Reversible Contraception (LARC) and Immediate Postpartum Long-Acting Reversible Contraceptives (IPLARC) options, warning signs of complications of pregnancy and postpartum, including when to contact the provider, and postpartum follow up.
- **All pregnant members are required to have certain screenings and these screenings must be notated in the member's medical record. All screenings with positive results shall be referred to the appropriate provider and follow up must occur to ensure services have been rendered. Examples of these screenings are**:
    - A brief verbal screening and intervention *for substance use* utilizing an evidence-based screening tool and an appropriate referral shall be made as needed.
    - Screened through the Controlled Substances Prescription Monitoring Program (CSPMP) once per trimester. For those members receiving opioids, appropriate intervention and counseling shall be provided, including referral of members for behavioral health services as indicated for substance use disorder (SUD) assessment and treatment.
    - Screening for all sexually transmitted infections (STIs) at the first prenatal visit. STI testing for syphilis, HIV, and Hepatitis C should happen at the first prenatal visit, third trimester, and at time of delivery. Member with positive results shall receive the appropriate counseling and treatment.
    - Perinatal Mood and Anxiety Disorders (PMAD) must be done at least once during pregnancy and then repeated 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.
        - When possible the referral should go to a Perinatal Mental Health Certified (PMH-C) behavioral health provider.
    - Screening the member using any norm-referenced validated screening tool for any medical health decisions or services that are needed. If additional care is needed, refer the member to their primary care provider and follow up to ensure the members needs are being met.
- Providers shall utilize evidence-based practices per ACOG and AAP which increase the initiation and

duration of breastfeeding, to include but not limited to, provider recommendation for breastfeeding, placement of the infant in skin-to-skin contact, early initiation of breastfeeding, no food or drink other than breastmilk, unless medically necessary, rooming in, as well as information on how to obtain a breast pump.
- Refer members for support services such as WIC, other community-based resources to support healthy pregnancy outcomes, including information on the ADHS Breastfeeding Hotline, and referrals to, home visitation programs for pregnant members and their children.
- In the event where a member loses eligibility, the member shall be notified where they may obtain low-cost or no-cost maternity services. They can go to the ADHS website to search for a provider/clinic: https://www.azdhs.gov/prevention/womens-childrens-health/informed-consent/index.php
- 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 Mercy Care 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

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 maternity 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. The items below must also be notated in the members medical records:

- Notify Mercy Care's Integrated Care Management (ICM) department by submitted an ACOG form when a member has tested positive for pregnancy. This will help us support the member by encouraging prenatal visit attendance and to ensure prenatal care is done in a timely manner.
- Provide postpartum care within a timely manner, which is prior to 12 weeks (84 days) 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.
- Encourage healthy behaviors during pregnancy to help reduce the risk of Low Birth Weight and Very Low Birth Weight (LBW/VLBW) and maternal mortality.
- Monitor newborn weight by documenting LBW/VLBW and making a referral to an appropriate provider and to our Integrated Care Management (ICM) department.
- Provide education to members that support breastfeeding success per ACOG and AAP guidance, which includes the provision of breast pumps and accessories.
- Testing for all sexually transmitted infections (STIs) at the first prenatal visit.
- Testing for STIs, including syphilis and HIV/AIDS, at delivery.
- Discuss and offer family planning services and supplies, such as LARC and IPLARC.
- 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.

- Refer members to any appropriate community resources/programs such as WIC, Raising Special Kids, Home Visiting Programs, SNAP, etc.
- Screen members for perinatal mood and anxiety disorders and refer them to a BH provider if needed.
- If a member has a substance use disorder (SUD), 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.
- If a member has a mental health diagnosis, be sure to have a treatment plan in place that monitors their medications to ensure appropriate care in completed throughout their pregnancy, after delivery, and including if they are breastfeeding.
- 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.
- Monitor maternal pregnancy-related mortality and health disparities during both the prenatal and postpartum period.

Mercy Care Can Help Reschedule Missed Prenatal and Postpartum Visits

To help address 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 them listing the date and time of the appointment.
- If the patient misses an appointment, providers can notify the EPSDT/MCH Department and our outreach staff will contact the member by letter and phone to assist them in rescheduling their appointment. During the phone call, the member will also receive education on the importance of showing up for scheduled appointments.
    - Providers can notify the EPSDT/MCH Department by completing the **EPSDT/MCH Missed Appointment Log and faxing it to us.** The log can be found here: Mercy Care Provider Website - Under Provider Forms.

Arizona Perinatal Psychiatry Access Line (A-PAL)

The University of Arizona created a behavioral health hotline for medical providers to help reduce mental illness and mortality in pregnant and postpartum patients by guiding frontline health care providers in perinatal psychiatric management.

Providers have real-time access to perinatal psychiatrists via the Perinatal A-PAL Hotline. This is a free service for medical providers. Providers can use this phone line to ask questions and review treatment options for their patients with perinatal psychiatric disorders and reproductive mental health concerns. The hours of operation are Mon-Fri 8:30 a.m.- 4:30 p.m.

Phone: 888-290-1336

Website: https://apal.arizona.edu/perinatal

Addressing Perinatal Mood Disorders and Anxiety

In February 2024, the American College of Obstetricians and Gynecologists (ACOG) released guidance explaining the importance of screening ALL perinatal women for perinatal period for mood disorders, depression, and anxiety, as well as referring them for treatment. By addressing these conditions during their visits, it will help educate and empower your patients and their families, as well as helps to reduce the stigmas associated with mental health conditions.

According to the ACOG, signs of depression onset can be found in:

- 27% of women, prior to pregnancy
- 33% of women, during pregnancy
- 40% of women, during the postpartum period

The ACOG and the AAP suggest screening for mood disorders and anxiety at these times:

- At their 1st OB perinatal appointment
- At an OB appointment in the 3rd trimester (24-to-28-week gestation period)
- At their postpartum appointment (prior to 12 weeks or 84 days post-delivery)
- At the baby's well child visits during their 1st year (see note below for additional details)

Note: Per AHCCCS AMPM 410 and 430, OBGYN providers should screening their patients using the timelines listed above. AHCCCS also states that pediatric providers should be screening the birthing parent for perinatal mood and anxiety disorders (PMAD) at the baby's 1st, 2nd, 4th, and 6th well child visits.

Perinatal Mood and Anxiety Disorder Screening Tools

Providers must use a validated screening tool that focuses on the prenatal and postpartum needs of members regarding depression or other mood and anxiety disorders. Examples of validated tools are:

- Depression- Edinburgh Postnatal Depression Screen (EPDS), 10 questions
- Depression- Patient Health Questionnaire-9 (PHQ-9), 9 questions
- Anxiety- General Anxiety Disorder 7 Screen (GAD-7), 7 questions
- Posttraumatic Stress Disorder (PTSD)- PC-PTSD, 4 questions
- Posttraumatic Stress Disorder (PTSD)- PCL-C in the appendix of the PC-PTSD, 17 questions
- Bipolar Disorder- Mood Disorder Questionnaire (MDQ), 14 questions
- Safety/Suicide Risk- EPDS or PHQ-9 positive results – use the Patient Safety Screener
- Combined Screening Tool: EPDS, MDQ, GAD-7, PC-PTSD-5, 39 questions (2 pages)
- Combined Screening Tool: PHQ-9, MDQ, GAD-7, PC-PTSD-5, 38 questions (2 pages)

Note: Per AHCCCS AMPM 410 and 430, OBGYN and EPSDT providers must save the screening tool, along with the score, to the members medical records. If the results were positive, providers must also notate if counseling was conducted, if a referral was made, and any follow up done to verify the referral has been completed.

Perinatal Mood and Anxiety Disorder Counseling and Referrals

Per the AMPM 410 and 430 policies, if their screening outcome is a positive result, providers should provide counseling and be available to answer questions the member may have. The provider must also make a referral to a qualified healthcare provider in a timely manner so members can get the care they need and to keep them and the baby be safe. Once a referral is made, the provider must follow up on the referral to ensure an appointment was set and the member has gone to the appointment.

If a member has not gone to their referral appointment, providers can reach out to the member to help them, notating any barriers preventing the member from going to their appointment. Providers can also complete the **EPSDT/MCH Provider Missed Appointment Log** and fax it to the MCH Coordinators. This missed visit log can be found on the Mercy Care Provider Website – under Forms. Once received, the MCH Coordinators will then provide additional outreach to the member.

Perinatal Mood and Anxiety Disorder Resources

- ACOG February 2024 Guidance: https://www.acog.org/programs/perinatal-mental-health/implementing-perinatal-mental-health-screening
- ACOG List of Validated Screening Tools including the combined tools listed above: https://www.acog.org/programs/perinatal-mental-health/patient-screening

Substance Use Disorder (SUD) During Pregnancy

Substance Use Disorders (SUDs) are treatable, chronic diseases characterized by a problematic pattern of use of 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. Providers must follow ACOG guidelines for pregnant members with a SUD or Medications for Opioid Use Disorder (MOUD). Their care should include:

An individualized plan of care for each identified pregnant member with SUD, including:

- Consents for Coordination of Care with patient's SUD treatment provider
- Medication dosage adjustment when needed
- Evidence-based breastfeeding recommendations and precautions
- Naloxone prescription
- A pain treatment plan for delivery and postpartum has been discussed

Screenings for additional health issues related to SUD and Social Determinants of Health (SDOH), including:

- HIV, Syphilis, STIs, Hepatitis
- Psychiatric disorders
- Medical Conditions such as hypertension, diabetes, etc.
- Trauma, Intimate partner violence
- Barriers to care

Ensure that each member has a plan of safe care in place prior to hospital discharge, including:

- Behavioral health services, appointments, and medications
- Safe plan for infant care
- Nutritional supplementation for parent and baby

Substance Use Disorder (SUD) During Pregnancy Resources

Mercy Care has created a flyer for providers called: **Prenatal and Postpartum Substance Use Resources** Providers may receive this flyer during site visits or providers can reach out to our MCH Coordinators for a copy. The flyer can also be downloaded from the Mercy Care Provider Website –Provider Forms. The flyer includes:

- Residential facilities that offer help to women with substance use disorders (SUD)
- Residential facilities that also offer outpatient options for women with substance use disorders (SUD)
- Facilities that offer help to women that participate in the Medication Assisted Treatment (MAT) program
- Substance Use Treatment Locator Websites
- Behavioral Health, Substance Use, and Crisis Hotlines

These are just a few examples of what may be listed on the flyer:

- **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
- **Hushabye Nursery** (Specialty Care Nursery): https://www.hushabyenursery.org/ or 480-628-7500
- **Jacob's Hope** (Specialty Care Nursery): https://jacobshopeaz.org/ or 480-398-73732
- **Family Support & Home Visitation**: https://strongfamiliesaz.com/
- **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. www.MaricopaSHIFT.com or 602-526-6116

Maternity Provider Audits – Screenings and Documentation

To ensure our members are receiving the care they need, Mercy Care will be conducting quarterly provider audits. The provider audit selection is random, and if selected, then we will be requesting medical records. During the audit we will be looking for the use of a validated behavioral health screening tool, the score received, if any counseling has taken place, if a referral was made in a timely manner, and if there was follow up completed to ensure the member attended the referred appointment. We will also be noting if the screening was completed at the appropriate date/time. For more details on the required dates/times of the visits, the requirements, and additional tools that are available, refer to the above section, *Addressing Perinatal Mood Disorders and Anxiety.*

Breastfeeding Guidance and Education

Providers must use the evidence-based practices outlined by the ACOG and AAP. The ACOG and AAP encourage providers to educate members on the importance of breastfeeding. Provider education and recommendations should include placement of the infant in skin-to-skin contact, rooming in, how to obtain a breast pump, early initiation of breastfeeding, encouraging breastfeeding for the first couple years, if medically appropriate. The ACOG also suggests that there is no food or drink other than breastmilk for the first 6 months, if medically appropriate.

Note: While the MCH Coordinators are auditing medical records for the appropriate use of Perinatal Mood Disorders and Anxiety screening tools, they will also review the notes to ensure the above breastfeeding education is taking place.

AGOC 2021 Guidance: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/02/breastfeeding-challenges
ACOG 2023 Practice Advisory: https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2023/02/duration-of-breastfeeding-update

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). Bloodspot Newborn Screening Panel, hearing, congenital heart defect, and, if indicated, bilirubin screening tests are conducted, including initial and secondary screenings, in accordance with 9 A.A.C. 13, Article 2 and the

newborn hearing screening must be performed per state statute A.R.S. § 36-694.

ADHS 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.**

ADHS Newborn Screening Resources

- Newborn Screening- Resources to Get Started
- Bloodspot Screening Reference Range – Updated 09/01/2024
- Arizona's Newborn Screening Panel of 35 disorders – including Spinal Muscular Atrophy (SMA), X Linked Adrenoleukodystrophy (X ALD), Pompe Disease (by 1/1/2024) and Mucopolysaccharidosis Type 1 (as of 01/01/2024).
- 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
- Sickle Cell Anemia Screening ACT Sheet

ADHS Educational Resources

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

mercy care

Family Planning

Family Planning Services and Supplies

In order to allow members to make informed decisions, providers should offer counseling on their family planning options. These discussions should provide accurate, up-to-date information regarding available family planning methods and prevention of sexually transmitted infections (STIs).

The discussion should be age-appropriate and include information on:

- Prevention of unplanned pregnancies.
- Counseling for unwanted pregnancies.
- The member's short term and long-term goals.
- Spacing of births at least 18 months apart 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 infections (STIs), including prevention and abstinence, as well as changes in sexual behavior and lifestyle that promote the development of good health habits.
- Annual STI testing for syphilis, which begins at 15 years old.
- Assist members that have lost AHCCCS eligibility and help them find low or no cost primary care and a provider that offers family planning services and supplies.
    - Additional links can be found in the Resource section of this manual.
- Address any barriers to care the member may be experiencing. Providers can also share this information with Mercy Care so we can provide additional outreach.

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 regardless of gender during their wellness visits as well as 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).

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 infections (including syphilis, chlamydia, and HIV). Such discussions must be informative, yet free from coercion or pressure and documented in the member's medical record.

Members may choose to obtain family planning services and supplies from any appropriate provider regardless of whether or not the family planning provider works with us at Mercy Care. We do not require prior authorization for members to obtain family planning services and supplies from an out-of-network provider.

Members in their third trimester of pregnancy or if they just delivered a baby

This is the perfect time for providers to talk with the member/patient about their LARC (long-acting reversible contraceptives) and IPLARC (immediate postpartum long-acting reversible contraceptives) options, such as IUD's or implants. Be sure to discuss the benefits and the risks so they are fully informed. By discussing their family planning options during the third trimester or after delivery, then the provider may be able to provide it before they leave the hospital.

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

- Natural family planning education or referral
- Contraceptive counseling
- Oral contraceptives
- Injectable contraceptives
- LARC (long-acting reversible contraceptives) and IPLARC (immediate postpartum long-acting
- reversible contraception) such as subdermal implantable contraceptive (implanted under the
- skin) and Intrauterine devices (IUDs)
- Vaginal rings, diaphragms, and condoms
- Foams, suppositories, jellies, and creams
- Post-coital emergency oral contraception within 72 hours after unprotected sexual intercourse (mifepristone, also known as Mifeprex or RU-486, is not post-coital emergency oral contraception)
- 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 all members, regardless of gender
    - Annual syphilis testing begins at age 15 years old.
- Associated medical and laboratory examinations and radiological procedures, including ultrasound studies related to family planning
- Treatment of complications resulting from contraceptive use, including emergency treatment.
- Pharmaceuticals are covered when associated with medical conditions related to family planning or other medical conditions

When performing a sterilization procedure, be sure to remind them that these procedures are not effective immediately. During the first three months, another form of birth control must be used to prevent pregnancy. At the end of three months, it is expected that a specific test will be done to confirm that the person is sterile.

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

STI Testing Provider Audits

To ensure our members are receiving the care they need, Mercy Care will be conducting quarterly provider audits. The provider audit selection is random, and if selected, then we will be requesting medical records. During the audit we will be looking for STI testing (syphilis specifically) to ensure the testing has been completed on an annual basis for members 15 years old and older, the results of the testing, if any counseling has taken place, and if treatment was required and completed. The audit will include any provider offering services to members aged 15 years old and older, such as PCPs, Pediatricians, and Gynecologists.

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.

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 individuals by quitting or reducing the use of smoking, chewing, and/or using other tobacco products (e.g., e-cigarettes and vaping). 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.

For personal coaching: 1-800-QUIT-NOW (1-800-784-8669) or 1-855-DEJELO-YA (1-855-335-3569)
ASHLine Quit Coaching: 1-800-55-66-222
ASHLine Enrollment Form: https://ashline.quitlogix.org/en-US/Enroll-Now

Tobacco Cessation Resources

- ASHLine: https://www.azdhs.gov/ashline/
- Tobacco Free Arizona: https://www.azdhs.gov/prevention/chronic-disease/tobacco-free-az/index.php
- ADHS Tobacco, Vape & E-Cigarettes: https://www.azdhs.gov/prevention/chronic-disease/tobacco-vape-e-cigarettes/index.php
- Mercy Care Website: https://www.mercycareaz.org/wellness/community-resources
- CDC Tobacco Cessation Materials: https://www.cdc.gov/tobacco/php/tobacco-control-programs/cessation-materials.html

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

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. 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)

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)

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 are subject to change. Always check the website below for the most recent information.

Timeframes, Transportation, Eligibility, and Referrals

Appointment Timeframes

Following AHCCCS ACOM 417, providers are required to schedule appointments for eligible members according to the timeframes listed below. Providers are subject to random audits by the Mercy Care Network Management department to ensure these timeframes are being met.

Mercy Care is also here to help. We can help members set up their appointments. They can get help from our Prevention and Wellness Outreach Department or when they call Member Services. If the member needs a listing of our Member Services phone numbers, they 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 (or earlier if their condition requires it)
- 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 (or earlier if their condition requires it)
- 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 (or earlier if their condition requires it)
- Office Wait Time Requirements – less than 45 minutes

Maternity

- 1st trimester – within 14 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 (or earlier if their health requires it)
- Office Wait Time Requirements – less than 45 minutes

Behavioral Health

- Initial Assessment/Screening/Evaluation – within 7 calendar days of the initial referral/request
- Initial Appointment - For 18 years old and older – within 23 calendar days of the initial assessment
    - For DCS CHP and 17 years old and under – within 21 calendar days of the initial assessment
- Subsequent Behavioral Health Services – within 45 calendar days from identifying the need (or earlier if their health condition requires it)
- Urgent Care – within 24 hours from identifying the need (or earlier if their health condition requires it)
- Office Wait Time Requirements – less than 45 minutes

DCS CHP members have a few specific timeframes that must followed. These timeframes are outlined in ACOM 417 as well as in the DCS CHP Medical Treatment Policy, Chapter 3 – Section 7.1 and 7.2.

DCS CHP Specific Timeframes

- Well Visits by an EPSDT provider – within 30 days after initial placement in out-of-home care and annually thereafter.
- Dental Assessments – within 30 days of placement for children ages one year and older, and semi-annually thereafter.
- Behavioral Health
    - Rapid Response – within 72 hours of being notified that the child was removed from their home (or earlier if their health condition requires it or there if there are dangerous or threatening behaviors towards themselves or others)
    - Initial Screening or Evaluation – within 7 calendar days of the initial referral/request
    - Initial Appointment – within 21 calendar days after any screening or evaluation
    - Subsequent Behavioral Health Services – within 21 calendar days from identifying the need (or earlier if their health condition requires it)
    - Office Wait Time Requirements – less than 45 minutes

For more details on the DCS EPSDT and Dental Timeframe Requirements, you can visit the DCS website – Under Medical and Behavioral Health Services Policy – Chapter 3 – Section 7.1.
For more details on the DCS Rapid Response (Behavioral Health) Requirements, you can visit ACOM 417 or DCS website – Under Medical and Behavioral Health Services Policy – Chapter 3 – Section 7.2.
For additional information on behavioral health services for persons in the legal custody of DCS and adopted children in accordance with A.R.S. § 8-512.01, refer to ACOM 449.

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. 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 is cancelled or changed, the member must call Member Services to cancel the transportation or have it changed to the new date/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 and 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. There are providers that can help with all MCH and EPSDT services such as maternity, women's health, well visits, blood lead testing an treatment, as well as family planning services and supplies. The member will have to call the clinic 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
- ADHS Women's Clinics (including maternity and family planning): https://www.azdhs.gov/prevention/ womens-childrens-health/informed-consent/index.php

Referrals

Healthcare Providers play an essential role in the healthcare system to prevent and manage common health conditions. They also help guide patients to make health decisions and recommend appropriate treatment. It's important for providers to refer members to specialists outside of their scope, as well as to available resources within the community. By submitting these referrals, providers can help address some of the social determinants of health (SDOH) that are affecting our members. This can also have a positive impact on health outcomes for people with complex needs. For example, referring to any available community resources can be essential in helping members receive access to care, as well as relieve some of the barriers to care that members may be experiencing. Referrals can also empower our members and their families by educating them on how to find and get the services they need in the community.

To address some of the social determinants of health (SDOH) needs in Arizona, AHCCCS created the Whole Person Care Initiative (WPCI). AHCCCS teamed up with Contexture (Arizona's health information exchange – HIE) and collaborated with 2-1-1 Arizona and Solari Crisis & Human Services to implement a single, statewide closed-loop

referral system called CommunityCares. CommunityCares is free for AHCCCS providers and community-based organizations. Health care providers that are not yet enrolled in CommunityCares must maintain a Community Resource Guide with information on local resources that provide support for Health-Related Social Needs. For more information on this program, visit: https://contexture.org/communitycares/

Referral Requirements

As noted in the AMPM Ch 430 – EPSDT Policy, EPSDT focuses on continuity of care by assessing health needs, providing preventive screenings, initiating needed referrals, and completing recommended medical treatment and appropriate follow up.

EPSDT providers must:

- Refer members for evaluation, follow-up, diagnosis, and treatment. Treatment is to be initiated within 60 days of the referral.
- Refer members to the appropriate provider for evaluation, diagnosis, and treatment for any screenings with positive results.
- Refer the member for dental treatments by one years old.
- Refer a member to care management for both physical and behavioral health care, if appropriate, to treat their health care needs.
- Refer members under 3 years old to AzEIP for therapies, if appropriate, to treat their health care needs.

Here is a list of a few important referral examples, including but not limited to:

- Therapy Programs such as physical, occupational, or speech.
- Developmental Programs for Children such as CRS, DDD, ALTCS, and AzEIP.
- Specialists such as a vision, hearing, dental, developmental specialist, a nutritionist, or a dietician.
- Nutritional Supplementation Programs such as WIC and SNAP.
- Mental Health Referrals such as Behavioral Health, SUD or MOUD Treatment Specialists, or Crisis.
- High-Risk Perinatal Programs such as Hushabye Nursery, Jacob's Hope, etc.
- Community Resources such as Home Visitation Programs, Early Head Start, Head Start, Raising Special Kids, Birth to Five/Fussy Baby, the ADHS Breastfeeding Hotline, and First Things First.

Referral Requirements

As noted in AMPM Ch 410, 411, and 420 policies, providers can help support member continuity of care by referring members to qualified specialists and when appropriate, our care management department.

MCH providers:

- Refer members to their PCP when they have a newly discovered medical condition.
- Refer members to a qualified specialist for evaluation, follow-up, and treatment if they have a BH screenings with positive results and you are unable to provide the appropriate treatment.
- Refer members with a high-risk pregnancy to a qualified specialist and care management.
- Refer any newborns that are born with low birth weight/very low birth weight (LBW/VLBW) to care management and to a qualified specialist for evaluation, diagnosis, and treatment.
- Refer members to available community resources when appropriate. (Examples listed above)

Home Visitation Programs and Other Community Resources

Home Visitation Program Resources

Home visitation programs are ***free***, effective tools that provide coaching and education to pregnant/postpartum women, first time parents, and families with children up to age 5 on how to improve their health and wellbeing. Each program sends a trained nurse or specialist to their home, and each has their own approach on how they provide support and education for the family. There are a few programs that run multiple types of home visitation programs, such as Southwest Human Development, Strong Families AZ, and Parents Partners Plus.

Parents Partners Plus

Parents Partners Plus is a network of home visitation programs that help families create a healthy future. They help expecting parents or families with a child aged 0-5 living within Maricopa County choose the right program. They can also help if connect you with other programs called Fussy Baby, Side by Side, and Smooth Way Home, or connect you with programs that address breastfeeding, postpartum depression, childhood developmental milestones and birthing mothers transitioning into life as a parent. Parents Partners Plus is supported by the home visitation programs listed below such as Southwest Human Development and First Things First.
(602)633-0732
https://parentpartnersplus.com/about-us/

Southwest Human Development (SWHD)

The goal of their child development and mental health programs is to address all aspects of a child's development and to support early relationships and promote healthy development. SWHD supports a network of ***free*** home visitation programs: Healthy Families and Nurse Family Partnership. They also support other programs such as the Birth to Five Hotline, Fussy Baby program and the Newborn Intensive Care Program.
(602)266-5976
https://www.swhd.org/programs/health-and-development/

Strong Families AZ

Strong Families AZ is a network of ***free*** home visiting programs that helps pregnant members and families with children birth to age 5 raise healthy children ready to succeed in school and life. It is free and voluntary, and families receive regular support and coaching in the comfort of their own home. Their home visitors are trained nurses, social workers and/or trained family educators. Below is a list of their home visitation programs.
https://strongfamiliesaz.com/programs/

Home Visitation Programs

Arizona Health Start

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

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. They get to know you and your family, so we can help you get the resources you need.
https://strongfamiliesaz.com/program/arizona-health-start/
https://parentpartnersplus.com/contact/

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 Childcare. They provide an individualized approach for low-income pregnant members and

children age birth to five. They provide support and guidance on how to become self-sufficient.
https://strongfamiliesaz.com/program/early-head-start/
https://parentpartnersplus.com/contact/

Healthy Families Arizona

For families with an infant under 3 months old

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 your area.
https://strongfamiliesaz.com/program/healthy-families-arizona/
https://www.swhd.org/programs/health-and-development/healthy-families/
https://parentpartnersplus.com/contact/

Family Spirit

For Native American families with children under 3 years old

The *Family Spirit Program* is a culturally tailored home visitation program delivered by Native American paraprofessionals as a core strategy to support young Native parents from pregnancy to 3 years postpartum. 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/
https://parentpartnersplus.com/contact/

Maternal Early Childhood Sustained Home-visiting (MECSH)

For pregnant people and/or newborns who are up to 8 weeks post-discharge.

MECSH is an evidenced-based nurse home visiting program that helps pregnant women or parents with a child under 3 years old. MECSH supports the family as a whole to connect them to resources and education on how to have a healthy pregnancy and a healthy baby. Families will learn positive parenting skills, ways to bond and play with their baby, and skills to access community resources.
https://strongfamiliesaz.com/program/maternal-early-childhood-sustained-home-visiting-mecsh/

Nurse-Family Partnership

For first-time birthing mothers less than 28 weeks pregnant

Nurse-Family Partnership is a community healthcare home visitation program that will connect you with a nurse home visitor. They will visit you in your home throughout pregnancy and continue to visit until your baby is 2 years old.
https://strongfamiliesaz.com/program/nurse-family-partnership/
https://www.swhd.org/programs/health-and-development/nurse-family-partnership/
https://parentpartnersplus.com/contact/

Parents As Teachers
For families with a child on the way or under 5 years old
As a parent, you have a unique opportunity to be your child's first teacher. That's because most brain development occurs in the first few years of life. Parents As Teachers is a home visitation program that will show you how. Our Home Visitors will provide you with resources appropriate for your child's stage of development. This can help you develop a stronger relationship with your child and help prepare them for academic success.
https://strongfamiliesaz.com/program/parents-as-teachers/
https://parentpartnersplus.com/contact/

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/

South Phoenix Healthy Start
For people that are pregnant or have a child under 2 years old
Healthy Start is a community-based, family support program designed to increase the number of infants that live and remain healthy past one year of age. This program offers all their services for free, with no income guidelines. Examples of the services they offer are Doula services, behavioral health services, monthly or bi-monthly visits, support groups, and perinatal health education.
https://strongfamiliesaz.com/program/healthy-start/
https://parentpartnersplus.com/contact/

Additional Community Resources

2-1-1 Arizona Community Information and Referrals

Arizona Community Information and Referrals is a call center that can help you find many community services, including: Food banks, clothes, shelters, help to pay rent and utilities, health care, pregnancy health, help when you or someone else is in trouble, support groups, counseling, help with drug or alcohol problems, financial help, job training, transportation, education programs, adult day care, meals on wheels, respite care, home health care, transportation, homemaker services, child care, after school programs, family help, summer camps and play programs, counseling, help with learning, protective services.
Dial 2-1-1
https://211arizona.org/

4th Trimester of AZ

All families are embraced by their communities in their transition to parenthood.
We are an organization of families, health professionals, educators and local businesses that honors, supports and empowers all families of Arizona during their transition to parenthood and beyond.
(480)-269-1639
https://4thtrimesteraz.org/

ADHS 24 hour Pregnancy and Breastfeeding Helpline

Arizona Department of Health Services (ADHS) has a breastfeeding hotline that 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

ADHS - Office of Women and Children's Health

This site offers guidance on Women's Health, Oral Health, Children's Health, Maternal Health as well as information on Injury Prevention, the Stillbirth and Infant Mortality Action Plan, and information on Children and Youth with Special Health care Needs. Their goal is to reduce mortality and morbidity among women and children, eliminate health disparities in health outcomes and access to services, and increase access to care.
602-542-1025
https://www.azdhs.gov/prevention/womens-childrens-health/index.php

Affirm (formerly Arizona Family Health Partnership)

This federally funded program offers family planning, women's health services and education to Arizonans, regardless of their ability to pay. Call or go online to find a qualified health center near you.
https://www.affirmaz.org/

Arizona Opioid Assistance & Referral (OAR) Line

A no-cost, confidential hotline offers opioid advice, resources, and referrals 24 hours a day, 7 days a week. This Hotline is staffed with local medical experts at the Arizona and Banner Poison & Drug Information Centers who offer patients, family members or providers valuable opioid information.
1-888-688-4222
https://www.azdhs.gov/oarline

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/

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

Child and Family Resources

We offer free and effective prevention and education strategies for families, teens, and early educators. They support home visitation programs such as Healthy Families and Parents as Teachers. They also provide childcare

resources, the Nurturing Parenting Program, the Family Connections Program, as well as prevention programs such as Prevention Programs for Youth, Substance Misuse Prevention Programs, Sexual Risk Avoidance Education, and our brand-new Youth Mentoring Program.
1-888-241-5002
https://www.childfamilyresources.org/

Child Care Resource and Referral
CCR&R is a statewide program that helps families find childcare. They also support families raise healthy children by offering one-on-one assistance and educate parents on early learning and quality child care.
1-800-308-9000
https://www.azccrr.com

Count the Kicks App
A no-cost pregnancy app available to individuals who are in their third trimester of pregnancy. The app helps expectant parents learn about the importance of tracking fetal movements. Tracking these movements, in addition to regular prenatal visits, helps monitor the baby's well-being. You can download the app at https://countthekicks.org.

First Things First
Arizona's early childhood agency, committed to the healthy development and learning of young children from birth to age 5. They partner families and resources in the community 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/

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 behaviors during the first year of life. Our clinicians teach you ways to soothe and care for your baby. We'll also offer ways to reduce stress, and support in your important role as a parent.
(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, care that changes the course of their entire lives. They offer a safe and inclusive space where the birthing parents and babies can get integrative care and support that offers each child the best possible life outcomes.
Call or text to (480)628-7500
https://www.hushabyenursery.org/

Jacob's Hope
Jacob's Hope is a care center for newborns who are suffering with Neonatal Abstinence Syndrome (NAS), or withdrawals from prenatal exposure to drugs. Their staff provides 24-hour nurturing medical care for infants while the drugs leave their system. They also show moms and caregivers how to console the baby.
(480)398-7373
https://jacobshopeaz.org/

Lifewell Women's Residential (Will Become Terros on 10/1/2024)
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/

Maricopa County Lead Safe Phoenix Partnership
This program provides home visitation as well as community outreach and education, to people that live in the city of phoenix. There is no cost to participate in the program, but you must meet requirements. See their website for details on those requirements. Home visitors will provide blood lead testing to children under 6 years old, they will check your home for lead, educate you on lead poisoning and they will refer you to community resources if needed.
(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/

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/

Power Me A2Z
Free vitamins for young women for strong bones and teeth, shiny hair, strong nails, a healthy immune system, and preventing anemia. 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.azdhs.gov/powermea2z/

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.
602-506-9333
https://www.azdhs.gov/prevention/azwic/index.php https://www.maricopa.gov/1491/Women-Infants-Children-WIC