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ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

DATE: September 30, 2010

TO: Holders of AHCCCS Medical Policy Manuals

FROM: Maureen Sharp, Medical Policy Manager
Office of Medical Policy and Programs, AHCCCS

SUBJECT: AHCCCS Medical Policy Manual (AMPM)
Update 2010-06

There are numerous changes accompanying this update. **All changes are effective 10/1/2010.**

In response to significant fiscal challenges facing the State and substantial growth in the Medicaid population, AHCCCS has implemented several legislatively mandated changes to the adult (age 21 or older) benefit package. The AHCCCS Medical Policy Manual has been amended to reflect these changes. To review additional information such as the federal and state regulatory authority for these changes, refer to the “Benefit Changes” section of the AHCCCS website: <http://www.azahcccs.gov/reporting/legislation/sessions/2010/BenefitChanges.aspx>.

Also included in this update are other modifications to the AHCCCS Medical Policy Manual that represent more routine updates to AHCCCS Contractor requirements and technical modifications. If a modification is part of the adult benefit change, it will include the designation “*Adult Benefit Change*”.

Chapter 300 – Medical Policy for AHCCCS Covered Services

Chapter Overview

Language has been added to introduce Exhibit 300-3 which includes a descriptions and CPT and HCPCS codes impacted by the changes to Adult services (*Adult Benefit Change*).

Exhibit 300-1, AHCCCS Covered Services for Acute Care

The covered services matrix has been modified to correctly reflect the currently covered services for Title XIX for adults and EPSDT members and the covered services for Title XXI, members (*Adult Benefit Change*).

Exhibit 300-3 and attachments

This is a new exhibit which displays the services and the codes that are impacted by the adult benefit changes (*Adult Benefit Change*).

Policy 310-D, Dental services for members 21 years and older

Emergency adult dental services are eliminated. However, in accordance with federal law and the State Plan, AHCCCS will cover medical and surgical services furnished by a dentist only to

the extent that such services may be performed under State law either by a physician or by a dentist and such services would be considered a physician service if furnished by a physician. (*Adult Benefit Change*).

Policy 310-H, Health Risk Assessment and Screening Tests

Preventative examinations in the absence of any known disease or systems (well exams) are no longer covered for members age 21 or older (*Adult Benefit Change*).

Policy 310-P, Medical Supplies, DME, and Orthotic Prosthetic Devices

- Criteria related to lower limb prosthetics for adults has been added to policy
- Microprocessor controlled lower limbs and microprocessor controlled joints for lower limbs are no longer covered for members 21 years of age and older (*Adult Benefit Change*).
- The following are no longer covered for members 21 years and older,
 - Bone Anchored hearing Aids (BAHA)
 - Cochlear implants
 - Insulin Pumps
 - Percussive vestsHowever, supplies, equipment maintenance and repair of component parts will remain a covered benefit (*Adult Benefit Change*).

Policy 310-U, Foot and Ankle Services

Limitation has been added. Foot and ankle services provided by a podiatrist or podiatric surgeon are no longer covered. Services may be reimbursed if rendered by another clinician such as physician, NP or PA (*Adult Benefit Change*).

Policy 310-X, Rehabilitative Services (OT, PT, and Speech)

Outpatient physical therapy visits are limited to 15 visits per contract year. Services provided in inpatient settings including nursing facilities, nursing homes, custodial care facilities and schools are excluded from the visit limitation (*Adult Benefit Change*).

Policy 310-DD, Covered Transplants and Immunosuppressant Medications

Effective 10/1/2010, the following non-experimental transplants will not be covered for persons 21 years and older (*Adult Benefit Change*).

- Pancreas after kidney transplants
- Lung transplants
- Allogeneic unrelated hematopoietic cell (bone marrow) transplants
- Liver transplants for members with a diagnosis of Hepatitis C
- Heart transplants for non-ischemic cardiomyopathies

In addition to the elimination of coverage for certain organ transplants, there are multiple changes within the transplant policy that reflect current practice and requirements. Select modifications to transplant policy are highlighted below. For a comprehensive understanding of the modification to transplant policy the entire chapter should be reviewed.

- Overview - Explanation related to experimental service is removed, reader is referred to Arizona Administrative Code.

- Definitions added related to Adult Caregiver, Emergent Fulminate Hepatic/Liver Failure, Hematopoietic Stem Cell Transplant and Ischemic Cardiomyopathy.
- B.General Medical Conditions which must be considered, refer to the addition of the requirement that members with a history of current or remote substance abuse sign an agreement which states they will enroll in a post transplant substance abuse program that will continue for 12 months.

Policy 320-D, Reserved (formerly Cochlear Implantation)

Cochlear implants are no longer a covered benefit for members 21 years of age and older. Supplies, equipment maintenance and repair of component parts will remain a covered benefit. For Policy regarding members under the age of 21 please reference Policy 430 (*Adult Benefit Change*).

Policy 320-J, High Frequency Chest Wall Oscillation

High Frequency Chest Wall Oscillation Therapy (HFW) percussive vest are no longer a covered benefit for members 21 years of age and older. Supplies, equipment maintenance and repair of component parts will remain a covered benefit (*Adult Benefit Change*).

Chapter 400, Medical Policy for Maternal and Child Health

Policy 430 EPSDT Services, Section C. 8. Cochlear and Osseointegrated Implantation

Although no longer covered for adults, cochlear implants and osseointegrated implants (bone anchored hearing aids) remain a covered benefit under EPSDT. The requirements related to EPSDT members for these items have been relocated to Policy 430; previously these requirements were incorporated within Chapter 300.

Chapter 500, Care Coordination Requirements

Policy 510, Primary Care Providers PCPs

Changes were made to conform to A.R.S. § 36-2907 (*Adult Benefit Change*).

Exhibit 520-1, Acute Care Enrollment Transition Information Form

Outpatient physical therapy visits are limited to 15 for adult members. To assist in communication between contracted health plans, the acute care enrollment transition information form has been revised to include the number of outpatient physical therapy visits utilized. Please reference line 16A (*Adult Benefit Change*).

Chapter 700, School Based Claiming Program/ Direct Service Claiming

Policy 720, Covered Services, Section C, Therapies

The application of hot or cold packs is not a covered therapy service. This example of a modality was deleted.

Chapter 800, Fee-For-Service Quality and Utilization Management

Policy 820, Prior Authorization Requirements

Policies have been revised to comport with revision to adult benefits as described above (Chapter 300, Medical Policy for AHCCCS Covered Services) (*Adult Benefit Change*).

The sections of policy that have been impacted include:

C. Cochlear Implant

D. Dental Services

N. Medical Supplies, Durable Equipment and Orthotic/Prosthetic Devices

R. Foot and Ankle Services

T. Rehabilitation Therapies (Occupational, Physical and Speech)

Chapter 900, Quality Management and Performance Improvement Program

Policy 950, Credentialing and Recredentialing Processes

Policy has been modified to specifically address the supervision and credentialing requirements related to teaching physicians and teaching dentists. This new section is included as Section J, "Teaching Physicians and Teaching Dentists." Also please reference the AHCCCS Contractors Operations Manual, Policy 204 for specific requirements related to this topic.

Chapter 1000, Medical Management / Utilization Management

Policy 1010, General Requirements, Section C. MM/UM Administrative Oversight

Due to the benefit changes that will be implemented 10/01/10, section C 6 will reflect that a qualified professional has the ability to render a denial decision for excluded services under A.R.S. 36-2907 (*Adult Benefit Change*).

In addition a section has been added requiring Contractors to ensure consistent application of standards and clinical criteria to ensure consistent decisions are made that include inter-rater reliability criteria.

The language in section C 8 regarding delegated agreements was changed to better reflect contract language and to require a notification to AHCCCS within 30 days when actions such as notices to cure or sanctions are issued.

Chapter 1200, ALTCS, Services and Settings for Members who are Elderly and/or have Physical Disabilities and/or have Developmental Disabilities

Policy 1250-F, Therapies

Policies have been revised to comport with the revision to adult benefits as described above (Chapter 300, Policy 310-X Rehabilitative Services (OT, PT, and Speech) (*Adult Benefit Change*)).

Chapter 1600, Policy

Exhibit 1620-9, ALTCS Enrollment Transition Information Form

Outpatient physical therapy visits are limited to 15 for adult members. To assist in communication between contracted health plans, the ALTCS enrollment transition information form has been revised to include the number of outpatient physical therapy visits utilized (*Adult Benefit Change*).