410 - MATERNITY CARE SERVICES

EFFECTIVE DATES: 01/01/97, 06/27/00, 02/01/01, 08/07/01, 10/01/01, 02/14/03, 04/01/04, 08/01/05, 04/01/07, 10/01/08, 10/01/09, 02/01/11, 09/01/11, 10/01/11, 10/01/13, 03/01/14, 10/01/14, 10/01/15, 09/08/16, 01/10/18, 10/01/18, 10/01/19, 09/01/21, 01/25/23, 01/30/24, 10/01/24, 01/01/27

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I. PURPOSE

This policy applies to ACC, ACC-RBHA, ALTCS E/PD, DCS CHP (CHP), and DES DDD (DDD) Contractors; Fee-For-Service (FFS) Programs including: the American Indian Health Program (AIHP), DES DDD Tribal Health Program (DDD THP), Tribal ALTCS, and all FFS populations, excluding Federal Emergency Services Program (FESP), (For FESP, refer to AMPM Policy 1100). This Policy establishes requirements for the Contractor and ~~FFS~~ Providers serving FFS members[1] regarding Maternity Care Services.

II. DEFINITIONS

Refer to the AHCCCS ~~Contract and Policy~~ ACOM and AMPM[2] Dictionary for common terms found in this Policy ~~including but not limited to:~~.

~~CERTIFIED NURSE MIDWIFE (CNM)~~	~~CONTROLLED SUBSTANCES PRESCRIPTION MONITORING PROGRAM (CSPMP)~~	~~EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT)~~
~~FREE STANDING BIRTHING CENTERS~~	~~HIGH RISK PREGNANCY~~	~~LICENSED MIDWIFE (LM)~~
~~MATERNITY CARE~~	~~MATERNITY CARE COORDINATION~~	~~MEMBER~~
~~POSTPARTUM~~	~~POSTPARTUM CARE~~	~~PRACTITIONER~~
~~PRECONCEPTION COUNSELING~~	~~PRENATAL CARE~~	~~PRIOR AUTHORIZATION (PA)~~
~~SUBSTANCE USE DISORDER (SUD)~~[3]		

[1] Revised to align with Policy standard language. Revised throughout the Policy.
[2] Revised to updated title and link.
[3] Removed terms table to align with AHCCCS ACOM and AMPM Dictionary.

III. POLICY

The following designations have been determined by the American College of Obstetricians and Gynecologists (ACOG) as outlined:

1. Early term (37 0/7 weeks of gestation through 38 6/7 weeks of gestation).
2. Full term (39 0/7 weeks of gestation through 40 6/7 weeks of gestation).
3. Late term (41 0/7 weeks of gestation through 41 6/7 weeks of gestation).
4. Post term (42 0/7 weeks of gestation and beyond).

All Maternity Care Services shall be delivered by qualified providers as specified in this Policy. ~~and shall be provided in compliance with the most c~~Current ACOG standards for obstetrical and gynecological services shall be considered in the clinical management of pregnant and postpartum members. Coverage for maternity care services is determined under applicable AHCCCS policies and medical necessity requirements.[4] Prenatal care, labor/delivery, and postpartum care services may be provided by a Licensed Midwife (LM) within their scope of practice, while adhering to AHCCCS risk-status consultation/referral requirements. All cesarean sections shall include medical documentation surrounding medical necessity. In addition, all inductions and cesarean sections done prior to 39 weeks shall follow the ACOG guidelines. Any inductions performed prior to 39 weeks or cesareans sections performed at any time that are found not to be medically necessary based on the nationally established criteria are not eligible for payment. AHCCCS covers a full continuum of Maternity Care Services for all eligible, enrolled members of childbearing age.

The 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.

In addition, related services such as outreach and family planning services are provided, whenever appropriate, based on the member's current eligibility and enrollment. Refer to AMPM Policy 420 and AMPM Exhibit 400-3.

[4] Clarification of policy.

A. CONTRACTOR REQUIREMENTS FOR PROVIDING MATERNITY CARE SERVICES

The Contractor shall ensure that providers adhere to the maternity care requirements in this Policy and[5] establish and operate a maternity care program with program goals directed at achieving optimal birth outcomes. The minimum requirements of the Contractor's maternity care program shall include, but is not limited to:

1. Sufficient numbers of appropriately qualified local personnel in order to meet the requirements of the maternity care program for eligible enrolled members and achieve contractual compliance.

2. Demonstration of an established process for assuring:
   a. Network physicians, practitioners, and LMs adhere to the highest standards of care, including the use of a standardized medical risk assessment tool for initial and ongoing risk assessments, and appropriate consults/referrals for increased risk or high-risk pregnancies using standard guidelines such as those established by ACOG,
   b. The maternity care providers maintain a complete medical record, documenting all aspects of maternity care,
   c. The m~~M~~aternity care providers are aware of and encouraged to use the Arizona Perinatal and Pediatric Psychiatry Access Line (A-PAL[6]) when questions surrounding mental health or substance use treatment, including medication management, arise,
   d. The ~~M~~maternity care providers educate members about healthy behaviors during the perinatal period, including the importance of proper nutrition, dangers of lead exposure to 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 opioid use, interconception health and birth[7] spacing, family planning options, including Immediate Postpartum Long Acting Reversible Contraception (IPLARC) options, warning signs of complications of pregnancy and postpartum, including when to contact the provider, and postpartum follow-up,
   e. High-risk pregnant members have been referred to and are receiving appropriate care from a qualified physician, such as a Maternal-Fetal Medicine (MFM) specialist, [8]and
   f. The members are referred to support services such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), as well as other community-based resources to support healthy pregnancy outcomes, including information about, 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.

[5] Moved from section C Maternity Care Providers to section A Contractor Requirements.
[6] Corrected the name of the psychiatry access line.
[7] Added the word "birth" before spacing for clarity.
[8] Clarified that services from maternal-fetal specialists are covered for high-risk members.

3. The provision of written member educational outreach~~,~~ including but not limited to the following topics ~~(and as specified in AMPM Exhibit 400-3)~~[9]:
   a. The provision of information regarding the opportunity to change Contractors to ensure continuity of prenatal care to newly assigned pregnant members and those currently under the care of an out-of-network provider,
   b. The information on how to obtain pregnancy-related services and assistance with scheduling appointments,
   c. A statement that there is no copayment or other charge for pregnancy-related services as specified in ACOM Policy 431,
   d. A statement that assistance with medically necessary transportation as specified in AMPM Policy 310-BB is available to obtain pregnancy related services,
   e. The importance of timely and personalized prenatal and postpartum care, including prenatal and[10] postpartum services that are available,
   f. Healthy pregnancy measures (addressing nutrition, sexually transmitted infections, HIV testing, alcohol, opioids, and substance use and other risky behaviors, measures to reduce risks for low/very low infant birth weight, recognizing active labor, etc.),
   g. Dangers of lead exposure to people who are pregnant and their developing babies, and how to prevent exposure,
   h. Support resources and programs, including but not limited to WIC, the Strong Families AZ home visitation programs, the ADHS Breastfeeding Hotline, Early Head Start/Head Start, the Vaccines for Children (VFC) program, and the Birth to 5 Helpline,
   i. Perinatal mood and anxiety disorders,
   j. Maternal and neonatal[11] ~~R~~risks associated with cesarean sections and elective inductions prior to 39 weeks gestation,
   k. Ways to limit labor and birth interventions as recommended by ACOG,
   l. Pregnancy and postpartum warning signs that require contacting a provider,
   m. Maternity care practices that are supportive of breastfeeding and breastfeeding information ~~as specified in AMPM Exhibit 400-3~~[12],
   n. Safe sleep and ways to reduce Sudden Infant Death Syndrome (SIDS)/Sudden Unexpected Infant Death (SUID) risk,
   o. Interconception health and birth[13] spacing recommendations and family planning options, including Immediate Postpartum Long-Acting Reversible Contraceptives (IPLARC) as specified in AMPM Policy 420 and AMPM Exhibit 400-3, and
   p. Other Contractor-selected topics.

   The topics listed above may be addressed separately~~,~~ or combined into one written outreach material; however, each topic shall be covered as specified in this Policy and AMPM Exhibit 400-3. The Contractor may utilize various venues to meet these requirements as specified in AMPM Exhibit 400-3.

[9] Removed duplicative language.
[10] The word "personalized" was added to align with tailored member-centered care and clarified that members shall be informed on covered prenatal services.
[11] Added maternal and neonatal language for elective inductions and cesarean sections prior to 39 weeks.
[12] Removed duplicative language.
[13] Added the word birth before spacing for clarity.

4. Written new member assessment procedures that require~~for the~~ providers ~~that include~~ to identify~~ing~~ risk factors ~~through the use of a~~using a standardized, comprehensive assessment tool ~~covering~~ that addresses psychosocial, nutritional, medical and educational factors ~~(available from~~consistent with current ACOG recommendations~~)~~[14].

5. Designation of a maternity care provider for each enrolled pregnant member for the duration of their pregnancy and postpartum care. Such designations shall be consistent with AHCCCS Contract requirements, allowing freedom of choice, while not compromising the continuity of care. Members who transition to a new Contractor or become enrolled during their third trimester shall be allowed to complete maternity care with their current AHCCCS registered provider, regardless of contractual status, to ensure continuity of care.

6. Mandatory availability of maternity care coordination services for enrolled pregnant members who are determined to be medically or socially at-risk/high-risk by the maternity care provider or the Contractor. This includes identified difficulties with navigating the health care system, evident by missed visits, transportation difficulties, or other perceived barriers.

7. Mandatory provision of initial prenatal care appointments within the established timeframes, as specified in ACOM Policy 417.

8. Verification of pregnancy, to ensure that the above timeframes are met, and to effectively monitor that members are seen in accordance with those timeframes.

9. Provide timely provision of medically necessary transportation services, as specified in AMPM Policy 310-BB.

10. Implementation of written protocols to inform pregnant members and maternity care providers of voluntary prenatal Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome (HIV/AIDS) testing, and the availability of medical counseling and treatment, as well as the benefits of treatment, if the test is positive:
    a. The Contractor shall include information to encourage pregnant members to be tested and provide instructions on where testing is available as specified in AMPM Exhibit 400-3, and
    b. The Contractor shall report the number of pregnant members who are HIV/AIDS-positive, using Attachment A, as specified in Contract Section F, Attachment F3 Contractor Chart of Deliverables[15].

11. Participation in community and quality initiatives, including but not limited to, efforts to reduce maternal mortality and morbidity and address health disparities in maternal and infant health within the communities served by the Contractor.

12. Participate in reviews of the Maternity Care Services program conducted by AHCCCS as requested, including provider visits and audits.

[14] Clarified that the assessment tool shall be consistent with ACOG recommendations since ACOG does not endorse a specific screening instruments.
[15] Added reference to align with Contractor Chart of Deliverables.

13. Outreach and education activities to identify currently enrolled pregnant members and enter them into prenatal care as soon as possible. The program shall include protocols for service providers to notify the Contractor promptly when members have tested positive for pregnancy. In addition, the Contractor shall have an ongoing process to monitor and evaluate the effectiveness of outreach activities for all pregnant members. If activities prove to be ineffective, the Contractor shall implement different outreach activities.

14. Process for the identification and management of ~~to address~~ substance use disorders (SUD) ~~treatment, referral, and follow-up specific to~~among ~~maternity~~ pregnant and postpartum members, per ACOG guidelines, including but not limited to utilization of the Controlled Substances Prescription Monitoring Program (CSPMP), ~~Neonatal Abstinence Syndrome (NAS)~~ use of validated screening tools, access to and coordination of and Medications for Opioid Use Disorder (MOUD), and care coordination for infants affected by prenatal substance exposure.[16]

15. Process for the ~~i~~identification and management of perinatal mood and anxiety disorders (PMAD) during ~~and after~~ pregnancy and the postpartum period, including ~~for~~ referral of members to the appropriate health care providers if a positive screen is obtained. The Contractor shall:
    a. ~~R~~require the use of any norm-criterion referenced validated screening tool to assist the provider in assessing ~~the~~ prenatal and postpartum ~~needs of~~ members for depression, anxiety, and other perinatal mood disorders at least once during pregnancy and repeated at the postpartum visit. ~~regarding depression or other mood and anxiety disorders and decisions regarding health care services provided by the maternity care provider or subsequent referral to the plan/entity responsible for the provision of behavioral health services, if clinically indicated.~~
    ~~a.~~ Monitor provider compliance with screening requirements and ensure members with positive screening results receive appropriate counseling, care coordination, and referral to qualified medical or behavioral health providers as clinically indicated.
    b.
    ~~Process for monitoring provider compliance for perinatal and postpartum depression and anxiety screenings being conducted at least once during the pregnancy and then repeated at the postpartum visit, with appropriate counseling and referrals made, if a positive screening is obtained.~~[17]

~~14.~~16. Monitor~~ing~~ and evaluate~~ion~~ of cesarean section and elective induction rates prior to 39 weeks gestation, as well as implementation of interventions to decrease the incidence of occurrence, including addressing variations in provider cesarean section rates for first-time pregnancies with a term, singleton baby in a vertex (head down) position.

~~15.~~17. Monitoring and evaluation of infants born with low/very low birth weight, and implementation of interventions to decrease the incidence of infants born with low/very low birth weight.

[16] Added validated screening tools, access and coordination of MOUD, and care coordination for infants affected by prenatal substance exposure.
[17] Combined the prenatal and postpartum PMAD screening requirements.

~~16.~~18. Monitoring and evaluation to ensure that maternity care practices that support breastfeeding success are being utilized per ACOG and American Academy of Pediatrics (AAP) guidance to include provision of breast pumps and accessories.

~~17.~~19. Monitoring and evaluation to ensure timely and personalized prenatal and postpartum care ~~Return visits are scheduled~~ as specified within ACOG standards. ~~A process, with verification, shall be in place to monitor these appointments and ensure timeliness. The Contractor shall include the first and last prenatal care dates of service and the number of obstetrical visits that the member had with the provider on claim forms to AHCCCS regardless of the payment methodology.~~[18]

~~The Contractor shall continue to pay obstetrical claims upon receipt of claim after delivery and shall not postpone payment to include the Postpartum visit. Rather, the Contractor shall require a separate "zero-dollar" claim for the Postpartum visit.~~**Error! Bookmark not defined.**[19]

~~18.~~20. Monitoring and evaluation of maternal mortality and implementation of interventions to decrease the occurrence of pregnancy-related mortality and health disparities in both the prenatal and postpartum period.

~~19.~~21. Monitoring and evaluation ~~e~~ of[20] postpartum activities and interventions to improve the utilization rate implemented where needs are identified.

~~The Contractor shall reimburse provider claims for Global Obstetrical (OB) codes (i.e., 59400, 59510, 59610, and 59618), if billed in accordance with the requirements outlined in the AHCCCS Fee-for-Service Provider Billing Manual.~~

B. CONTRACTOR REQUIREMENTS FOR THE MATERNITY AND FAMILY PLANNING SERVICES PROGRAM PLAN

The Contractor shall have a written Maternity and Family Planning Services Program Plan (inclusive of Work Plan and Work Plan Evaluation) that addresses minimum Contractor requirements as specified in ~~Section A of~~[21] this Policy, as well as the objectives of the Contractor's program that are focused on achieving AHCCCS requirements.

It shall also incorporate monitoring and evaluation activities for these minimum requirements, as specified in the Maternity and Family Planning Services and Supplies Program Plan Checklist[22]. ~~found at: www.azahcccs.gov/Resources/GuidesManualsPolicies/index.html.~~ The Maternity and

[18] The requirement to include the first and last prenatal care dates and number of Obstetric (OB) visits is being removed throughout the policy as this is tied to the global OB bundled methodology which will no longer be effective as of 1/1/2027.
[19] Global Obstetric (OB) bundle language is removed throughout the policy to align with the American Medical Association (AMA). New obstetric codes will replace the bundled global obstetric payment for maternity care services effective 1/1/2027.
[20] Aligned language with other bullets.
[21] "Section A" removed and revised to more general language to avoid missing future revisions.
[22] Replaced website with hyperlink.

Family Planning Services Program Plan and Supplies Program Checklist shall be submitted as specified in the Contract Section F, Attachment F3, Contractor Chart of Deliverables[23] and is subject to AHCCCS approval.

C. MATERNITY CARE PROVIDER REQUIREMENTS

The maternity care providers shall ensure ~~Contractor shall ensure that providers adhere to the following maternity care requirements, including but not limited to~~:[24]

1. ~~The Maternity care providers shall follow the~~Current ~~-~~ACOG standards of care~~,~~ are considered in the clinical management of pregnant and postpartum members ~~including the use of a standardized medical risk assessment tool and ongoing risk assessment~~[25].

2. The ~~LMs, if included in the provider network, shall adhere to the r~~requirements specified in AHCCCS policy, procedures, and Contract are adhered to. ~~and~~The LMs, if included in the Contractors provider network, shall also adhere to[26] AAC R9-16-111 through 113. The LMs providing services to Fee-For-Service (FFS) members shall adhere to the requirements contained within AHCCCS policies and procedures.

~~The Maternity care providers shall ensure that:~~[27]

3. A standardized, comprehensive assessment that addresses psychosocial, nutritional, medical and educational factors is used initially and ongoing, consistent with current ACOG recommendations,[28]

4. High-risk members have been referred to a qualified provider, such as referral to an MFM specialist, and are receiving appropriate care,

5. The members' medical records are appropriately maintained and ~~document~~ all aspects of the maternity care provided are documented,

6. The members ~~shall be~~ are notified that in the event of loss of eligibility for services, they may contact the Arizona Department of Health Services (ADHS) Hotline for referrals to low-cost or no-cost services,

[23] Added to reference the Contractor Chart of Deliverables for alignment.
[24] Moved Contractor language to section A Contractor Requirements and added a new lead in "Maternity care providers shall ensure".
[25] Clarification of policy.
[26] Updated language to fit with the lead in sentence throughout section.
[27] Decreased indent of bullet to flow with the lead in sentence.
[28] Moved assessment language from section C1 to C3a.

7. ~~The providers shall utilize e~~Evidence-based practices are used, 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, and rooming in,

8. All pregnant members are screened through the Controlled Substances Prescription Monitoring Program (CSPMP) once per trimester, and for those members receiving opioids, appropriate intervention and counseling shall be provided, including referral of members for behavioral health services as indicated for s~~S~~ubstance u~~U~~se d~~D~~isorder**Error! Bookmark not defined.** (SUD) assessment and treatment,

9. All pregnant members ~~shall~~ receive a brief verbal screening and intervention for substance use utilizing an evidence-based screening tool and ~~an appropriate~~ refer~~ral~~ members for additional assessment or treatment as indicated~~shall be made as needed~~,

10. All pregnant members are screened for s~~S~~exually t~~T~~ransmitted i~~I~~nfections~~Z~~ (STI), including syphilis, at the
    a. First prenatal visit,
    b. Third trimester, and
    c. Time of delivery.
    Refer to ARS 36-693 and AAC R9-6-391 for Arizona state law regarding serologic testing for syphilis.

11. The ~~M~~members are educated about healthy behaviors during pregnancy, including the importance of proper nutrition, dangers of lead exposure to 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, family planning options as specified in AMPM Policy 420, warning signs of complications of pregnancy and postpartum, including when to contact the provider, and postpartum follow-up,

12. Perinatal depression and anxiety screenings are conducted at least once during the pregnancy and then repeated at the postpartum visit with appropriate counseling and referrals made if a positive screening is obtained. ~~Perinatal depression and anxiety screening is considered part of the global service and is not a separately reimbursable service:~~

13. ~~Providers shall refer to any n~~Norm-referenced validated screening tools are used to assist the provider in assessing the mental health needs of members during the perinatal period and decisions regarding health care services provided by the Primary Care Provider (PCP) or subsequent referral to the plan/entity responsible for the provision of behavioral health services if clinically indicated.

14. The ~~M~~members ~~shall be~~are referred ~~for~~ to support services, such as WIC, as well as other community-based resources, in order to support healthy pregnancy outcomes,

15. The timely delivery and personalized prenatal and ~~P~~postpartum services ~~shall be provided~~ to members ~~within the postpartum period according to~~ consistent with ACOG ~~guidelines~~ recommendations and shall adhere to current performance measures ~~as~~ specified in Contract. ~~The maternity care provider shall utilize a separate "zero-dollar" claim for the postpartum visit, and~~
~~The first and last prenatal care dates of service, as well as the number of obstetrical visits that the member had with the provider, are recorded on all claim forms submitted to the Contractor regardless of the payment methodology used.~~

D. ADDITIONAL RELATED SERVICES

1. AHCCCS related services with special policy and procedural guidelines for FFS and Contractor providers include, but are not limited to:
   a. Group prenatal care:
      i. AHCCCS covers group prenatal care, eligible for enhanced provider reimbursement, under the following conditions:
         1) The primary facilitator/billing provider is an AHCCCS-registered provider for whom maternity care services are within their scope of practice,
         2) The site has been accredited or is pending accreditation as a CenteringPregnancy® site by the Centering Healthcare Institute®,
         4) Each group prenatal care visit is at least 1.5 hours in duration, with a minimum of two and maximum of twenty participants, and
         5) Individual member records of attendance and documentation ~~must~~ shall[29] be maintained by the provider and made available to AHCCCS or to the Contractor upon request.
      ii. The CenteringPregnancy® providers are eligible for enhanced reimbursement for each visit, per member, for up to 10 visits,
      iii. ~~The~~ Group visits may be supplemented with individual visits as determined medically[30] necessary by the provider,
      iv. ~~The~~Supplementary i~~I~~ndividual visits are not eligible for enhanced reimbursement and shall be billed according to general coding guidelines ~~are considered part of the global service,~~ and**Error! Bookmark not defined.**
      v. In order to receive enhanced reimbursement for group prenatal care visits, providers who are accredited or pending accreditation ~~must~~ shall submit the Reference Table Review Update (RTRU) form along with supporting documentation of their accreditation status. Providers ~~must~~ shall include the AHCCCS ID that corresponds to the name of the provider/billing entity on the accreditation documentation in order for the code to be added as a provider's specific exception.

[29] Revised to align with Policy standard language. Revised throughout the Policy.
[30] Added to clarify that the determination must be made by medical necessity.

b. Doulas:
   i. ~~The~~ Doula services are covered for AHCCCS members during pregnancy, labor and delivery, and up to one year postpartum under the following conditions:
      1) The d~~D~~oula is certified through the Arizona Department of Health Services (ADHS),
      2) The d~~D~~oula is an AHCCCS-registered provider,
      3) The services provided are within the scope of practice for d~~D~~oulas pursuant to AAC R9-16-901 through 909,
      4) The d~~D~~oula services are provided in complement to, and do not replace, prenatal, labor and delivery, and postpartum care provided by a physician, Certified Nurse Midwife, ~~Licensed Midwife~~LM, or other licensed provider for which maternity care is within their scope of practice, and
      5) The member is referred for d~~D~~oula services by a provider.
   ii. While provider referral is required for doula services, it is not required that the member experience a complication or high-risk pregnancy in order to be referred for doula services. If the member is pregnant or within one-year postpartum, medical necessity is met,
   iii. The Contractor shall not require prior authorization in order for a pregnant or postpartum member to receive doula services, and
   iv. There is no minimum or maximum number of visits required.~~, and~~
   ~~v. The Doula services are separately reimbursable, and are not included in the global OB bundle.~~

c. Human donor milk:
   AHCCCS covers medically necessary pasteurized human donor milk provided by a milk bank in certain circumstances, as specified in AMPM Policy 430.

d. Home uterine monitoring technology:
   i. AHCCCS covers medically necessary home uterine monitoring technology for members with premature labor contractions before 35 weeks gestation, as an alternative to hospitalization,
   ii. These guidelines refer to home uterine activity monitoring technology and do not refer to daily provider contact by telephone or home visit, and
   iii. If the member has one or more of the following conditions, home uterine monitoring may be considered:
      1) Multiple gestation, particularly triplets or quadruplets,
      2) Previous obstetrical history of one or more births before 35 weeks gestation, or
      3) Hospitalization for premature labor before 35 weeks gestation with a documented change in the cervix, controlled by Tocolysis and ready to be discharged for bed rest at home.

e. The l~~L~~abor and delivery services provided in Free Standing Birthing Centers:
   For members who meet medical criteria specified in this Policy, AHCCCS covers Free Standing Birthing Centers when labor and delivery services are provided by maternity care providers:

i. Only pregnant AHCCCS members, for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated, may be scheduled to deliver at a Free-Standing Birthing Center. Risk status shall be determined by the attending physician or CNM using the standardized assessment tools for high-risk pregnancies (ACOG, or National Association of Childbearing Centers). In any area of the risk assessment where standards conflict, the most stringent standard shall apply. The age of the member shall also be a consideration in the risk status evaluation; members younger than 18 years of age are generally considered high risk. Refer to the AAC R9-16-111 through 113 for a more detailed explanation of what are not considered low-risk deliveries, nor deliveries appropriate for planned homebirths in the home setting or births in Free Standing Birthing Centers, and

ii. Labor and delivery services rendered through free standing birthing centers shall be provided by a physician or by a Certified Nurse Midwife (CNM) who has hospital admitting privileges for labor and delivery services, or an LM who is following licensing and practice requirements as specified in AAC R9-16-111 through 113.

f. Licensed Midwife (LM) services:

i. AHCCCS covers maternity care and coordination provided by LMs for FFS members or enrolled members if LMs are included in the provider network. In addition, members who choose to receive maternity services from this provider type shall meet eligibility and medical criteria specified in this Policy,

ii. Risk status shall initially be determined at the time of the first visit, and each trimester, thereafter, using the current standardized assessment criteria and protocols for high-risk pregnancies from the ACOG,

iii. A risk assessment from the ACOG shall be conducted when a new presenting complication or concern arises to ensure proper care and referral to a qualified physician or CNM, if necessary,

iv. Before providing midwife services, documentation certifying the risk status of the member's pregnancy shall be submitted to the Contractor. In addition, a consent form signed and dated by the member shall be submitted, indicating that the member has been informed and understands the scope of services that shall be provided by the LM, including the risks to a home delivery. Members initially determined to have a high-risk pregnancy, or members whose physical condition changes to high-risk during the course of pregnancy, shall immediately be referred to an AHCCCS registered physician within the provider network of the member's Contractor for Maternity Care Services,

v. In addition to the maternity care provider requirements listed in this Policy, the requirements, and limitations to the scope of practice for LMs is located in AAC R9-16-111 through 113,

vi. Labor and delivery services provided by an LM cannot be provided in a hospital. LMs shall have a plan of action, including the name and address of an AHCCCS registered physician and an acute care hospital in close proximity to the planned location of labor and delivery for referral, in the event that complications should arise. This plan of action shall be submitted to the AHCCCS Chief Medical Officer or designee for FFS members, or to the Contractor Medical Director or designee for members enrolled with a Contractor,

vii. Upon delivery of the newborn, the LM is responsible for conducting newborn examination procedures, including a mandatory Bloodspot Newborn Screening Panel and referral of the infant to an appropriate health care provider for a mandatory hearing screening, as well as a second mandatory Bloodspot Newborn Screening Panel and a second newborn hearing screening (if infant's first hearing screening indicates further assessment is needed). Refer the infant and/or member to an appropriate health care provider for follow-up care of any assessed problematic conditions. Refer to AAC R9-16-111 through 113, and

viii. In addition, the ~~Licensed Midwife~~LM shall notify the member's Contractor or the AHCCCS Newborn Reporting Line for infants born to FFS members, of the birth no later than 24 hours after the birth, in order to enroll the newborn with AHCCCS.

g. ~~The~~ Labor and delivery services provided in a home setting:

i. Only AHCCCS members, for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated, may be scheduled to deliver in the member's home. Refer to AAC R9-16-111 through 113 for a more detailed explanation of what are not considered low-risk deliveries, nor deliveries appropriate for planned births in the home setting or births in Free Standing Birthing Centers,

ii. Risk status shall initially be determined at the time of the first visit, and each trimester thereafter, by the member's maternity care provider, using the current standardized assessment criteria and protocols for High-Risk Pregnancies from the ACOG,

iii. For members who meet medical criteria specified in this Policy, AHCCCS covers labor and delivery services provided in the home by the member's maternity provider: physicians, CNMs, or LMs,

iv. A risk assessment shall be conducted when a new presenting complication or concern arises to ensure appropriate care and referral to a qualified provider, if necessary,

v. Physicians and CNMs who render home labor and delivery services shall have admitting privileges at an acute care hospital in close proximity to the site where the services are provided in the event of complications during labor and/or delivery,

vi. For each anticipated home labor and delivery, LMs who render home labor and delivery services shall have an established plan of action, including the name and address of an AHCCCS-registered physician and an acute care hospital in close proximity to the planned location of labor and delivery for referral, in the event that complications should arise. This plan of action shall be submitted to the AHCCCS Chief Medical Officer or designee for FFS members, or to the Contractor Medical Director or designee for members enrolled with a Contractor,

vii. Upon delivery of the newborn, the physician, CNM or LM is responsible for conducting newborn examination procedures, including a mandatory Bloodspot Newborn Screening Panel and referral of the infant to an appropriate health care provider for a mandatory hearing screening, as well as a second mandatory Bloodspot Newborn Screening Panel and second newborn hearing screening (if first hearing screening indicates further assessment is needed). The maternity care provider shall refer the infant and/or member to an appropriate health care provider for follow-up care of any assessed problematic conditions (Refer to AAC R9-16-111 through 113), and

viii. In addition, the maternity care provider shall notify the member's Contractor or the AHCCCS Newborn Reporting Line of the birth for infants born to FFS members. Notification may also be made using the AHCCCS Online Provider website newborn

notifications link. Notification shall be given no later than 24 hours after the birth in order to enroll the newborn with AHCCCS.

h. Circumcision of newborn male infants:
   i. Pursuant to ARS 36-2907, routine circumcision for newborn males is not a covered service, and
   ii. The circumcision is a covered service under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for males only when it is determined to be medically necessary. The procedure requires Prior Authorization (PA) by the Contractor Medical Director or designee for enrolled members, or the AHCCCS Chief Medical Officer or designee for FFS members.

i. Extended stays for newborns related to status of parent's stay:
   i. AHCCCS covers no less than 48 hours of inpatient hospital care after a routine vaginal delivery and no less than 96 hours of inpatient care after a cesarean delivery, and
   ii. The attending health care provider, in consultation with an agreement by the parent, may discharge the parent or newborn prior to the minimum length of stay. A newborn may be granted an extended stay in the hospital of birth when the parent's continued stay in the hospital is beyond the minimum 48- or 96-hour stay, whichever is applicable. In addition, if the parent's stay is to extend beyond 48/96 hours, an extended stay for the newborn shall be granted if the parent's condition allows for parent-infant interaction and the child is not a ward of the State or is not to be adopted. PA is required for extended stays for newborn infants for the FFS population.

j. AHCCCS Request for ~~S~~stillbirth supplemental ~~request~~[31]:
   i. A supplemental payment was implemented for payment to the ~~ACC~~ Contractor to cover the cost of delivery services when an enrolled member delivers during a prospective enrollment period. The supplemental payment applies to all births to members enrolled with ACC Contractors only, as specified in Contract and ACOM Policy 310. AHCCCS also pays this supplement to the Contractor when the infant is stillborn,
   ii. Stillbirth refers to those infants, deemed a fetal demise prior to delivery with a gestational age of at least 24 ~~and~~ 0/7 weeks. In order for the Contractor to be eligible to receive this payment, criteria shall be met. The stillborn infant shall have:
      1) Attained a weight of at least 600 grams, or
      2) Attained a gestational age of at least 24 ~~and~~ 0/7 weeks, as verified by the provider's obstetrical prenatal records (h~~H~~istory and p~~P~~hysical) including an e~~E~~stimated d~~D~~ate of d~~D~~elivery (EDD). An ultrasound report may also be used to verify EDD, when completed prior to 22 weeks gestation. A Ballard Assessment, completed at delivery by nursing and/or physician staff to determine physical maturity of the infant, confirming a gestational age of at least 24 0/7 weeks may also be used.
   iii. For stillbirths meeting one of the above medical criteria, the Contractor shall submit the maternal and newborn delivery record to confirm infant's weight, or gestational age, as well as the date/time of delivery and zero Apgar score using Attachment B, including results of syphilis testing,
   iv. Information shall be submitted as specified in Contract Section F, Attachment F3, Contractor Chart of Deliverables[32],

[31] Aligned with Contract language.
[32] Alignment with Contractor Chart of Deliverables.

v. No supplemental payment is provided for labor and delivery services rendered during the prior period coverage timeframe, or if the member was not assigned to the Contractor at the time labor and delivery services were rendered,
vi. Contractor requests for the payment shall be made within six months of the delivery date. Exceptions shall be considered on a case-by-case basis, and
vii. Incomplete documentation, including lack of Apgar scores, ~~will~~ shall result in denial of stillbirth supplement request,

k. Pregnancy termination as specified in ~~Section E below~~this Policy[33].

E. PREGNANCY TERMINATION

1. AHCCCS covers pregnancy termination if one of the following criteria is present:
   a. The pregnant woman suffers from a physical disorder, physical injury, or physical illness including a life-endangering physical condition caused by, or arising from, the pregnancy itself that would, as certified by a physician, place the member in danger of death unless the pregnancy is terminated,
   b. Pregnancy is a result of incest,
   c. The pregnancy is a result of rape, or
   d. The pregnancy termination is medically necessary according to the medical judgment of a licensed physician, who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or behavioral health problem for the pregnant woman by:
      i. Creating a serious physical or behavioral health problem for the pregnant woman,
      ii. Seriously impairing a bodily function of the pregnant woman,
      iii. Causing dysfunction of a bodily organ or part of the pregnant woman,
      iv. Exacerbating a health problem of the pregnant woman, or
      v. Preventing the pregnant woman from obtaining treatment for a health problem.

2. Requirements regarding PA:
   a. Except in cases of medical emergencies, the provider shall obtain a PA for all covered pregnancy terminations from the Contractor's Medical Director. PA for FFS pregnant members shall be obtained from the AHCCCS Chief Medical Officer or designee,
   b. The attending physician shall submit a request for review of the pregnancy termination qualifying diagnosis/condition to the Contractor Medical Director or designee for enrolled pregnant members with clinical information that supports the medical necessity for the procedure,
   c. The Contractor's Medical Director, or for FFS members, the AHCCCS Chief Medical Officer or designee shall review the PA request, as specified in Attachments C and D, and expeditiously authorize the procedure, if the documentation meets the criteria for justification of pregnancy termination, and
   d. In cases of medical emergencies, the attending physician shall submit all documentation of medical necessity to the Contractor or AHCCCS/Division of Fee-For-Service Management (DFSM), within two working days of the date on which the pregnancy termination procedure was performed.

[33] Removed "Section E" and revised to more general language to avoid misalignment.

3. Additional required documentation:
   a. The providers shall obtain a written consent and file in the member's medical record for a pregnancy termination,
   b. If the pregnant member is younger than 18 years of age or is 18 years of age or older and considered an incapacitated ~~adult~~ person[34] (as specified in ARS 14-5101), a dated signature of the pregnant member's parent/Health Care Decision Maker (HCDM) indicating approval of the pregnancy termination procedure is required,
   c. When the pregnancy is the result of rape or incest, documentation shall be obtained that the incident was reported to the proper authorities, including the name of the agency to which it was reported, the report number (if available), and the date the report was filed. This documentation requirement shall be waived if the treating physician certifies that, in their professional opinion, the member was unable, for physical or psychological reasons, to comply with the requirement,
   d. Follow Food and Drug Administration (FDA) medication guidance for the use of medications to end a pregnancy,
   e. Current standards of care per ACOG shall be utilized when the duration of pregnancy is unknown or if ectopic pregnancy is suspected,
   f. Pregnancy termination by surgery is recommended in cases when medications are used and fail to induce termination of the pregnancy. When medications are administered, the following documentation is also required:
      i. Name of medication(s) used,
      ii. Duration of pregnancy in days,
      iii. The date medication was given,
      iv. The date any additional medications were given (unless a complete abortion was already confirmed), and
   g. Documentation that pregnancy termination occurred.

4. Reporting requirements:
   a. The Contractor shall submit ~~the AHCCCS Certificate of Necessity for Pregnancy Termination~~Attachment C, as specified in Contract Section F, Attachment F3 Contractor Chart of Deliverables, and ~~&~~
   ~~a.~~b. The Contractor shall submit ~~AHCCCS Verification of Diagnosis by Contractor for Pregnancy Termination Requests~~[35] ~~(~~Attachment~~s C and~~ D~~,)~~ as specified in Contract Section F, Attachment F3 Contractor Chart of Deliverables[36], and
   ~~b.~~c. The Contractor shall submit a Pregnancy Termination Report, and the required documentation as listed in Attachment E, as specified in ~~the~~ Contract Section F, Attachment F3 Contractor Chart of Deliverables[37].

5. Monitoring:
   The Contractor shall ensure procedures to identify and monitor all claims and encounters with a primary diagnosis of pregnancy termination.

[34] Updated term to align with the statute.
[35] Removed names of deliverables in policy since it is unnecessary to include.
[36] Added reference to the Contractor Chart of Deliverables for alignment.
[37] Added reference to the Contractor Chart of Deliverables for alignment.