



AHCCCS Policy Update: Commercial Oral Nutritional Supplements

October 15, 2015

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Dear Care1st Providers and Staff:

AHCCCS revised AMPM Policies 310-GG Nutritional Assessments and Nutritional Therapy and EPSDT Services 430 including Exhibit 430-2 effective **October 1, 2015**. Outlined below are instructions/tips for completing the age appropriate Certificate of Medical Necessity (CMN) for Commercial Oral Nutrition Supplements and the documents that must accompany the CMN.

EPSDT Aged Members

When Completing the Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (EPSDT Aged Members – Initial or Ongoing Requests) please indicate (CMN is included on Page 3):

1. If request is Initial vs. Ongoing
2. Supplement name **and** quantity needed
3. Type of nutrition feeding: Sole source vs. supplemental (what % of nutrition consumed)
4. Which criteria were met to support the medical necessity for providing oral nutrition supplements using check boxes in the table labeled 'Member Meets the Criteria in the Left Column OR Meets at Least Two Criteria in the Right Column':
 - a. First column specifies patient has a chronic condition, is underweight (according to BMI or weight-for-length growth charts) AND there are no alternatives for adequate nutrition.
 - b. Second column requires 2 check marks if all criteria in first column could not be met.

Submit the Following Documents with CMN form:

1. Well/sick visit clinical notes with medical condition causing the issues with weight gain and supporting the boxes checked on the CMN
2. Documentation patient has trialed other alternative methods to achieve adequate nutrition (high calorie foods, frequent snacks, smoothies, etc) and length of time
3. History & Physical Assessment (for initial requests)
4. Current height and weight, growth charts, BMI (Age >2 years) and tolerance to therapy
5. Supporting documentation must be dated within 3 months of request
6. Request is valid for 6 months at a time.
7. Documentation demonstrating encouragement and assistance provided to the caregiver in weaning the member from supplemental nutritional feedings should be included, when appropriate.

Provider Network Operations
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Members 21 years of age and older

When Completing the Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (Members 21 Years of Age or Greater – Initial or Ongoing Requests) please indicate (CMN is included as Page 4):

1. If request is Initial vs. Ongoing
2. Supplement name **and** quantity needed
3. Type of nutrition feeding: Sole source vs. supplemental (what % of nutrition consumed)

Submit the Following Documents with CMN form:

1. Clinical notes with medical condition causing the issues with weight gain, documentation must support ALL of the requirements listed on the CMN form
2. Documentation that patient has trialed other alternative methods to achieve adequate nutrition (high calorie foods, frequent snacks, smoothies, etc) and length of time
3. History & Physical Assessment (for initial requests)
4. Current height and weight, BMI and tolerance to therapy
5. Supporting documentation must be dated within 3 months of request
6. Request is valid for no more than 6 months at a time

NOTE: All members receiving nutritional therapy must be physically assessed by their PCP, specialty provider, or registered dietitian at least once a year.

If you have any questions or need assistance in downloading the policies please contact Provider Network Operations at the numbers below.

Thank you!

EXHIBIT 430-2
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CERTIFICATE OF MEDICAL NECESSITY FOR COMMERCIAL ORAL NUTRITIONAL
SUPPLEMENTS (EPSDT AGED MEMBERS - INITIAL OR ONGOING REQUESTS)

MEMBER INFORMATION Member's AHCCCS ID Number: _____ Contracted Health Plan: _____

Member's Name: _____ Date of Birth: _____
Last First Initial

Members' Address: _____

Assessment performed by: _____ AHCCCS Provider ID: _____

Provider Specialty: _____ Telephone Number: _____ Assessment Date: _____

TYPE OF REQUEST

Initial Ongoing

PREFERRED SUPPLEMENT Type: _____

Substitution Permissible: Yes No

TYPE OF NUTRITION FEEDING

- Weaning from Tube Feeding Oral Feeding –Sole Source
 Oral Feeding – Supplemental Emergency Supplemental Nutrition

ASSESSMENT: Indicate which of the following criteria have been met to support that oral supplemental nutritional feedings are medically necessary. (Supporting documentation dated no earlier than 3 months prior to the date of this request must be submitted with the Certificate of Medical Necessity to support each of the criteria selected below.)

Member Meets the Criteria in the Left Column <i>OR</i> Meets at Least Two Criteria in the Right Column	
<input type="checkbox"/> 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.	<p style="text-align: center;">Use the space below, to indicate which <i>two</i> or more criteria have been met:</p> <input type="checkbox"/> Member is at or below the 10th percentile for weight-for-length/BMI, on the appropriate growth chart for their age and gender, for 3 months or more. <input type="checkbox"/> Member has reached a plateau in growth and/or nutritional status for more than 6 months, or more than 3 months if member is an infant less than 1 year of age. <input type="checkbox"/> Member has already demonstrated a medically significant decline in weight within the 3 month period prior to the assessment. <input type="checkbox"/> Member is able to consume/eat no more than 25% of nutritional requirements from age-appropriate food sources.
Additionally, Both of the Following Requirements Must be Met	
<ul style="list-style-type: none"> • 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 • 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. ** Refer to AMPM, Policy 430. 	

Initial and Ongoing Certificate of Medical Necessity is valid for a period of 6 months. Subsequent submissions must include a current physical assessment in the form of a clinical note or other supporting documentation that includes the members overall response to supplemental therapy and justification for continued supplement use. This must include the member's tolerance to formula, recent hospitalizations, current height/weight percentiles, and BMI percentile for members two years of age or older. Documentation demonstrating encouragement and assistance provided to the caregiver in weaning the member from supplemental nutritional feedings should be included, when appropriate.

Submitting Provider Signature

Date

Printed Name

Provider Type

Contact Number

