2.b. Rural Health Clinic Services

Rural health clinic services are limited to twelve (12) visits a year for recipients age 21 and older. This yearly limit is based on the State Fiscal Year (July 1 through June 30). The benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist and certified nurse midwife services. Recipients will be allowed twelve (12) visits per State Fiscal Year for rural health clinic services, physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services or a combination of the five. For physicians services, medical services provided by a dentist, office medical services furnished by an optometrist, certified nurse midwife services or rural health clinic core services beyond the 12 visit limit, extensions will be provided if medically necessary. **Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit.** Recipients under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

Rural Health Clinic core services are defined as follows:

(1) Physicians' services, including required physician supervisory services of nurse practitioners and physician assistants;

(2) Services and supplies furnished as an incident to a physician's professional services;

Services and supplies "incident to" the professional services of physicians, physician assistants and/or nurse practitioners are those which are commonly furnished in connection with these professional services, are generally furnished in the physician's office and are ordinarily rendered without charge or included in the clinic's bills; e.g., laboratory services, ordinary medications and other services and supplies used in patient primary care services.

5. a. Physicians' services, whether furnished in the office, the recipient's home, a hospital, a skilled nursing facility, or elsewhere

(1) Physicians' services in a physician's office, patient's home or nursing home are limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for recipients age 21 and older.

(a) Benefit Limit Details

The benefit limit will be considered in conjunction with the benefit limit established for rural health clinic services, medical services furnished by a dentist, office medical services furnished by an optometrist and certified nurse midwife services. Recipients will be allowed twelve (12) visits per State Fiscal Year for physicians' services, medical services provided by a dentist, rural health clinic services, office medical services furnished by an optometrist, certified nurse midwife services or a combination of the five. Recipients under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit.

(b) Extensions

For physicians services, medical services provided by a dentist, office medical services furnished by an optometrist, certified nurse midwife services or rural health clinic core services beyond the 12 visit limit, extensions will be provided if medically necessary.

(i) The following diagnoses are considered to be categorically medically necessary and **are exempt from benefit extension requirements:** Malignant neoplasm; HIV infection and renal failure.

(ii) Additionally, physicians' visits for pregnancy in the outpatient hospital are exempt from benefit extension requirements.

(2) Each attending physician/dentist is limited to billing one day of care for inpatient hospital covered days regardless of the number of hospital visits rendered.

(3) Surgical procedures which are generally considered to be elective require prior authorization from the Utilization Review Section.

(4) Desensitization injections - Refer to Attachment 3.1-A, Item 4.b. (12).

(5) Organ transplants are covered as described in Attachment 3.1-E.

5. a. Physicians' Services (Continued)

(6) Consultations are limited to two (2) per recipient per year in a physician's office, patient's home, hospital or nursing home. This yearly limit is based on the State Fiscal Year (July 1 through June 30). This limit is in addition to the yearly limit described in Item 5.(1). Extensions of the benefit limit will be provided if medically necessary for recipients in the Child Health Services (EPSDT) Program.

(7) Effective for dates of service on or after September 15, 1995, interactive consultations (telemedicine) are limited to two (2) per recipient. This yearly limit is based on the State Fiscal Year (July 1 through June 30). Extensions of the benefit limit will be considered for eligible recipients of all ages.

(8) Abortions are covered when the life of the mother would be endangered if the fetus were carried to term or for victims of rape or incest. The circumstances must be certified in writing by the woman's attending physician. Prior authorization is required.

5. b. Medical and surgical services furnished by a dentist (in accordance with Section 1905 (a)(5)(B) of the Act).

Medical services furnished by a dentist are limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for recipients age 21 and older.

The benefit limit will be considered in conjunction with the benefit limit established for physicians' services, rural health clinic services, office medical services furnished by an optometrist and certified nurse midwife services. Recipients will be allowed twelve (12) visits per State Fiscal Year for medical services furnished by a dentist, physicians' services, rural health clinic services, office medical services furnished by an optometrist, certified nurse midwife services or a combination of the five. For physicians services, medical services provided by a dentist, office medical services furnished by an optometrist, certified nurse midwife services or rural health clinic core services beyond the 12 visit limit, extensions will be provided if medically necessary. **Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit.** Recipients under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

Surgical services furnished by a dentist are not benefit limited.

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

b. Optometrists' Services (Continued)

(2) One eye exam every twelve (12) months for eligible recipients under 21 years of age in the Child Health Services (EPSDT) Program. Extensions of the benefit limit will be provided if medically necessary for recipients in the Child Health Services (EPSDT) Program.

(3) Office medical services provided by an optometrist are limited to twelve (12) visits per State Fiscal Year (July 1 through June 30). The benefit limit will be in conjunction with the benefit limit established for physicians services, medical services furnished by a dentist, rural health clinic services and certified nurse midwife services. Recipients will be allowed twelve (12) visits per State Fiscal Year for office medical services furnished by an optometrist, medical services furnished by a dentist, physicians services, rural health clinic services, certified nurse midwife services or a combination of the five. For physicians services, office medical services furnished by an optometrist, medical services furnished by a dentist, certified nurse midwife services or rural health clinic core services beyond the twelve (12) visit limit, extensions will be provided if medically necessary. **Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit.** Recipients in the Child Health Services (EPSDT) Program are not benefit limited.

c. Chiropractors' Services

(1) Services are limited to licensed chiropractors meeting minimum standards promulgated by the Secretary of HHS under Title XVIII.

(2) Services are limited to treatment by means of manual manipulation of the spine which the chiropractor is legally authorized by the State to perform.

(3) Effective for dates of service on or after July 1, 1996, chiropractic services will be limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for eligible Medicaid recipients age 21 and older. Services provided to recipients under age 21 in the Child Health Services (EPSDT) Program are not benefit limited. Chiropractic services require a referral by the recipient's primary care physician (PCP).

12. Prescribed drugs, dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist

a. Prescribed Drugs

(1) Each recipient age 21 or older may have up to six (6) prescriptions each month under the program. The first three prescriptions do not require prior authorization. The three additional prescriptions must be prior authorized. Family Planning**, tobacco cessation** and EPSDT prescriptions do not count against the prescription limit.

(2) The following categories of drugs are not covered:

a. agents used for weight reduction
b. agents used to promote fertility
c. agents used for cosmetic purposes or hair growth
d. vitamin and mineral products, except prenatal vitamins and fluoride preparations
e. DESI drugs or less than effective drugs as designated by the FDA **to have a CMS DESI rating of 5 or 6**
f. **select** sedatives and hypnotics in the benzodiazepine category **as well as their generic equivalents**
g. **select** cough and cold medications for recipients age 21 and older

(3) The State will reimburse only for the drugs of pharmaceutical manufacturers who have entered into and have in effect a rebate agreement in compliance with Section 1927 of the Social Security Act, unless the exceptions in Section 1902(a)(54), 1927(a)(3) or 1927(d) apply. The State permits coverage of participating manufacturers' drugs, even though it may be using a formulary or other restrictions. **Utilization controls will include prior authorization and may include drug utilization reviews.** Any prior authorization program instituted after July 1, 1991 will provide for a 24-hour turnaround from receipt of the request for prior authorization. The prior authorization program also provides for at least a 72 hour supply of drugs in emergency situations.

17. Nurse-Midwife Services

Any person possessing the qualifications for a registered nurse in the State of Arkansas who is also certified as a nurse-midwife by the American College of Nurse-Midwives, upon application and payment of the requisite fees to the Arkansas State Board of Nursing, be qualified for licensure as a certified nurse-midwife. A certified nurse-midwife meeting the requirements of Arkansas Act 409 of 1995 is authorized to practice nurse-midwifery.

Services provided by a certified nurse midwife are limited to twelve (12) visits a year for recipients age 21 and older. This yearly limit is based on the State Fiscal Year (July 1 through June 30). The benefit limit will be considered in conjunction with the benefit limit established for physicians services, medical services furnished by a dentist, rural health clinic services and office medical services furnished by an optometrist. Recipients will be allowed twelve (12) visits per State Fiscal Year for services provided by a certified nurse midwife, physicians services, rural health clinic services, medical services furnished by a dentist, office medical services furnished by an optometrist or a combination of the five. For services provided by a certified nurse midwife, physicians services, rural health care services, medical services furnished by a dentist or office medical services furnished by an optometrist beyond the twelve visit limit, extensions will be provided if medically necessary. **Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit.** Recipients under age 21 in the Child Health Services (EPSDT) program are not benefit limited.

2.b. Rural Health Clinic Services

Rural health clinic services are limited to twelve (12) visits a year for recipients age 21 and older. This yearly limit is based on the State Fiscal Year (July 1 through June 30). The benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist and certified nurse midwife services. Recipients will be allowed twelve (12) visits per State Fiscal Year for rural health clinic services, physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services or a combination of the five. For physician services, medical services provided by a dentist, office medical services furnished by an optometrist, certified nurse midwife services or rural health clinic core services beyond the 12 visit limit, extensions will be provided if medically necessary. **Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit.** Recipients under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

Rural Health Clinic core services are defined as follows:

(1) Physicians' services, including required physician supervisory services of nurse practitioners and physician assistants;

(2) Services and supplies furnished as an incident to a physician's professional services;

Services and supplies "incident to" the professional services of physicians, physician assistants and/or nurse practitioners are those which are commonly furnished in connection with these professional services, are generally furnished in the physician's office and are ordinarily rendered without charge or included in the clinic's bills; e.g., laboratory services, ordinary medications and other services and supplies used in patient primary care services.

4.c. Family Planning Services

(1) Comprehensive family planning services are limited to an original examination and up to three follow-up visits annually. This limit is based on the state fiscal year (July 1 through June 30).

5.a. Physicians' services, whether furnished in the office, the recipient's home, a hospital, a skilled nursing facility, or elsewhere

(1) Physicians' services in a physician's office, patient's home or nursing home are limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for recipients age 21 and older.

(a) Benefit Limit Details

The benefit limit will be considered in conjunction with the benefit limit established for rural health clinic services, medical services furnished by a dentist, office medical services furnished by an optometrist and certified nurse midwife services. Recipients will be allowed twelve (12) visits per State Fiscal Year for physicians' services, medical services provided by a dentist, rural health clinic services, office medical services furnished by an optometrist, certified nurse midwife services or a combination of the five. Recipients under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit.

(b) Extensions

For physicians services, medical services provided by a dentist, office medical services furnished by an optometrist, certified nurse midwife services or rural health clinic core services beyond the 12 visit limit, extensions will be provided if medically necessary.

(i) The following diagnoses are considered to be categorically medically necessary and **are exempt from benefit extension requirements:** Malignant neoplasm; HIV infection and renal failure.

(ii) Additionally, physicians' visits for pregnancy in the outpatient hospital are exempt from benefit extension requirements.

(2) Each attending physician/dentist is limited to billing one day of care for inpatient hospital covered days regardless of the number of hospital visits rendered.

5. a. Physicians' Services (Continued)

(3) Surgical procedures which are generally considered to be elective require prior authorization from the Utilization Review Section.

(4) Desensitization injections - Refer to Attachment 3.1-A, Item 4.b. (12).

(5) Organ transplants are covered as described in Attachment 3.1-E.

(6) Consultations are limited to two (2) per recipient per year in a physician's office, patient's home, hospital or nursing home. This yearly limit is based on the State Fiscal Year (July 1 through June 30). This limit is in addition to the yearly limit described in Item 5.(1). Extensions of the benefit limit will be provided if medically necessary for recipients in the Child Health Services (EPSDT) Program.

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6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

b. Optometrists' Services (Continued)

(2) One eye exam every twelve (12) months for eligible recipients under 21 years of age in the Child Health Services (EPSDT) Program. Extensions of the benefit limit will be provided if medically necessary for recipients in the Child Health Services (EPSDT) Program.

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e. DESI drugs or less than effective drugs as designated by the FDA **to have a CMS DESI rating of 5 or 6**
f. **select** sedatives and hypnotics in the benzodiazepine category **as well as their generic equivalents**
g. **select** cough and cold medications for recipients age 21 and older

(3) The State will reimburse only for the drugs of pharmaceutical manufacturers who have entered into and have in effect a rebate agreement in compliance with Section 1927 of the Social Security Act, unless the exceptions in Section 1902(a)(54), 1927(a)(3) or 1927(d) apply. The State permits coverage of participating manufacturers' drugs, even though it may be using a formulary or other restrictions. **Utilization controls will include prior authorization and may include drug utilization reviews.** Any prior authorization program instituted after July 1, 1991 will provide for a 24-hour turnaround from receipt of the request for prior authorization. The prior authorization program also provides for at least a 72 hour supply of drugs in emergency situations.

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Services provided by a certified nurse midwife are limited to twelve (12) visits a year for recipients age 21 and older. This yearly limit is based on the State Fiscal Year (July 1 through June 30). The benefit limit will be considered in conjunction with the benefit limit established for physicians services, medical services furnished by a dentist, rural health clinic services and office medical services furnished by an optometrist. Recipients will be allowed twelve (12) visits per State Fiscal Year for services provided by a certified nurse midwife, physicians services, rural health clinic services, medical services furnished by a dentist, office medical services furnished by an optometrist or a combination of the five. For services provided by a certified nurse midwife, physicians services, rural health care services, medical services furnished by a dentist or office medical services furnished by an optometrist beyond the twelve visit limit, extensions will be provided if medically necessary. **Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit.** Recipients under age 21 in the Child Health Services (EPSDT) program are not benefit limited.

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OFFICIAL NOTICE

DMS-2004-W-3

TO: **Health Care Provider – All Providers**

DATE:

SUBJECT: **Coverage of Tobacco Cessation Products through the Arkansas Medicaid Prescription Drug Program**

I. Introduction

In recognition of both the need and ability to facilitate tobacco cessation, Arkansas Medicaid will begin covering generic Zyban (bupropion for tobacco cessation), nicotine gum or nicotine patches. Participating providers must have prescriptive authority and the consultation must be in the scope of their practice. Effective for claims with dates of service on or after October 1, 2004, coverage of tobacco cessation products will be available with prior authorization to eligible Medicaid recipients.

Medicaid providers who will be authorized to provide the counseling services defined in this notice are: Physicians, Nurse Practitioners, Certified Nurse-Midwives, Rural Health Clinics (RHC), Federally Qualified Health Centers (FQHC), Dentists and Oral Surgeons. These services, when provided by FQHC and RHC providers are included in the encounter fee.

II. Coverage and Limitations

A. Reimbursement for generic Zyban if appropriate, and nicotine replacement therapy (NRT), either nicotine gum or nicotine patches will be available for up to two ninety-three day courses of treatment within a state fiscal year (SFY) (July 1- June 30) for eligible Medicaid recipients. Pregnant females will be allowed up to four ninety-three day courses of treatment per SFY. One course of treatment will be three consecutive months.

B. Counseling, which will be required by the prescriber to obtain the initial prior authorization (PA) for the pharmacological agents, will consist of reviewing the Public Health Service (PHS) guideline-based checklist with the patient in the initial PA. The prescriber must retain the counseling checklist in the patient records for audit. A copy of this checklist will be available on the Medicaid website at www.medicaid.state.ar.us.

Subsequent PAs will require prescriber referral to an intensive tobacco cessation program, such as SOS Works. A referral form will also be available on the Medicaid website.

The prescriber may use the following procedure codes for counseling: **99401 and 99402 each with a modifier of SE.** The Arkansas Medicaid maximum allowable fee for procedure code 99401 is $20.00 for one fifteen minute unit. Two counseling sessions will be allowed per SFY. The Arkansas Medicaid maximum allowable fee for procedure code 99402 is $25.00 for a thirty-minute unit, with a benefit limit of two counseling sessions per SFY. In order for Medicaid to cover procedure code 99402, the prescriber must refer the patient to an intensive tobacco cessation referral program such as SOS Works, for counseling options. A referral form will be available on the Medicaid website. The participating prescribing physician will be reimbursed for the counseling services in addition to the regular office visit.

Dentists and oral surgeons must use procedure codes **D9920 and D1320** when filing a claim on the American Dental Association (ADA) claim form. The Arkansas Medicaid maximum allowable fee for procedure code D9920 is $20.00 for one fifteen minute unit and has a benefit limit of two counseling sessions per SFY. The Arkansas Medicaid maximum allowable fee for procedure code D1320 is $25.00 and it has a benefit limit of two counseling sessions per SFY. In order for Medicaid to cover procedure code D1320, the dentist or oral surgeon must refer the patient to an intensive tobacco cessation referral program such as SOS Works for counseling options. The participating dentist or oral surgeon will be reimbursed for the counseling services in addition to the other dental services provided at the time of the visit.

Beneficiaries may receive two units of either 99401 or D9920 or a combination of both and two units of either 99402 and D1320 or a combination of both for a maximum allowable of four units per SFY.

C. Additional prescription benefits will be allowed per month for tobacco cessation products during the approved PA period and will not be counted against the monthly prescription benefit limit. One benefit will be allowed for generic Zyban if the physician believes that generic Zyban therapy is appropriate and one benefit for nicotine replacement therapy, either nicotine gum or patches.

D. To promote discontinuation of tobacco products by eligible Medicaid recipients for each month of the three month course of therapy, Arkansas Medicaid, if appropriate, will reimburse up to a thirty-one (31) day supply of generic Zyban not to exceed 62 tablets, and either nicotine gum up to a 31 day supply not to exceed 504 pieces; or nicotine patches up to a 31-day supply not to exceed 31 patches.

Pharmacy providers may receive one of the following error codes with the message when billing for nicotine replacement products: **S050**/**S060**-Host error message not available. The rejection reason for S050 is therapeutic duplication between Zyban and Wellbutrin. The rejection reason for S060 is additive quantity over amount allowed per 31 days.

E. Tobacco Cessation products will require a prescription and a prior authorization (PA). The criteria required for the PA can be found on the attached PA forms and these forms will be available on the Medicaid website. The prescribing physicians will process the PA through the voice response system (VRS). The PA begin date is the date requested on the VRS. The PA is effective for ninety-three days from the date requested. A national drug code (NDC) is necessary to request the prior authorization. The NDCs for the covered products are listed below. The NDCs will also be available on the Medicaid website.*****

GUM	00766004320	NICORETTE 2MG CHEWING GUM
GUM	00766004420	NICORETTE 4MG CHEWING GUM
PATCH	00135014702	NICODERM CQ 7MG/24HR PATCH
PATCH	00135014602	NICODERM CQ 14MG/24HR PATCH
PATCH	00135014502	NICOTINE CQ 21MG/24HR PATCH
PATCH	24385044010	NICOTINE 11MG/24HR PATCH
PATCH	24385068410	NICOTINE 22MG/24HR PATCH
PATCH	00009526901	NICOTROL 5MG/16HR PATCH
PATCH	00009527001	NICOTROL 10MG/16HR PATCH
PATCH	00009519702	NICOTROL 15MG/16HR PATCH
PATCH	00067604556	NICOTINE TRANSDERMAL SYSTEM
TABLET	00173055601	ZYBAN 150MG TABLET SA

*** NDCs are for reference only; they are not to be construed as approval for "brand medically necessary" prior authorization.**

F. Over the counter (OTC) as well as any legend products will be eligible for reimbursement. OTC products are not covered for long term care residents.

G. Tobacco cessation products are **not** subject to co-pay and do **not** count towards the monthly prescription limit. Counseling procedure codes (**99401, 99402 each with a modifier of SE, D9920 and D1320**) will not count against the twelve visits per SFY, but each procedure code is limited to two counseling sessions per SFY up to a maximum of four counseling sessions per SFY. Tobacco cessation services do **not** require a PCP referral.

Thank you for your participation in the Arkansas Medicaid Program.

Roy Jeffus, Director

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

If you have questions regarding this notice, please contact the EDS Provider Assistance Center at In-State WATS 1-800-457-4454, or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website**: www.medicaid.state.ar.us.**