ARKANSAS REGISTER

Transmittal Sheet

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For Office Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Medical Services

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Statutory Authority for Promulgating Rules Arkansas Code §§ 20-76-201, 20-77-107, and 25-10-129

Rule Title: PCP Visits and Act 569 of 2021

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Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Chloe Crater	chloe.crater@dhs.arkansas.gov	9/27/2022
Contact Person	E-mail Address	Date

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with the Arkansas Administrative Act. (ACA 25-15-201 et. seq.)

S. Elizabeth Pitman
Signature

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Director, Division of Medical Services
Title

September 27, 2022
Date

Revised 7/2015 to reflect new legislation passed in the 2015 Regular Session (Act 1258). This act changed the effective date from 30 days to 10 days after filing the rule.

TOC required

214.210 Advanced Practice Registered Nurse (APRN) Services Benefit Limits 7-1-22

A. For clients twenty-one (21) years of age or older, APRN services provided in a physician office, an APRN office, a patient's home, or nursing home are limited to sixteen (16) visits per state fiscal year (SFY) (July 1 through June 30).

The following services are counted toward the Service Benefit Limits established for the state fiscal year:

1. APRN services in the office, patient's home, or nursing facility
2. Physician services in the office, patient's home or nursing facility
3. Rural health clinic (RHC) encounters
4. Medical services furnished by a dentist
5. Medical services furnished by an optometrist
6. Certified nurse-midwife services
7. Federally qualified health center (FQHC) encounters

The established benefit limit does not apply to clients under age twenty-one (21).

Global obstetric fees are not counted against the -visit limit. Itemized obstetric office visits are not counted in the limit.

Extensions of the benefit limit will be considered for services beyond the established benefit limit when documentation verifies medical necessity. Refer to Section 214.900 of this manual for procedures for obtaining extension of benefits.

225.000 Outpatient Hospital Benefit Limit 7-1-22

Medicaid-eligible clients twenty-one (21) years or older are limited to a total of twelve (12) outpatient hospital visits a year. This benefit limit includes outpatient hospital services provided in an acute care, general, or a rehabilitative hospital. This yearly limit is based on the State Fiscal Year (SFY/July 1 through June 30).

A. Outpatient hospital services include the following:

1. Non-emergency professional visits in the outpatient hospital and related physician, advanced practice registered nurse (APRN), and physician assistant services.
2. Outpatient hospital therapy and treatment services and related physician, APRN, and physician assistant services.

B. Extension of benefits will be considered for clients based on medical necessity.

C. The Arkansas Medicaid Program automatically extends the outpatient hospital visit benefit for certain primary diagnoses. Those diagnoses are:

1. Malignant neoplasm (**View ICD Codes.**)
2. HIV infection and AIDS (**View ICD Codes.**)
3. Renal failure (**View ICD Codes.**)
4. Pregnancy (**View ICD Codes.**)
5. Opioid Use Disorder when treated with MAT (**View ICD OUD Codes.**)

D. When a Medicaid eligible client's primary diagnosis is one (1) of those listed above and the Medicaid eligible client has exhausted the Medicaid established benefit limit for outpatient hospital services and related physician, APRN, and physician assistant services, the provider does not have to file for an extension of the benefit limit.

E. All outpatient hospital services for clients under age twenty-one (21) in the Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program are not benefit limited.

F. Emergency and surgical physician services provided in an outpatient hospital setting are not benefit limited.

226.000 Physician Services Benefit Limit 7-1-22

Physician Program

A. For clients twenty-one (21) years of age or older, services provided in a physician's office, advanced practice registered nurse's (APRN) office, a patient's home, or nursing home are limited to sixteen (16) visits per state fiscal year (July 1 through June 30).

Clients under twenty-one (21) years of age in the Child Health Services/Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) Program are not subject to this benefit limit.

The following services are counted toward the service benefit limits:

1. Services of physicians in the office, client's home, or nursing facility.
2. Medical services provided by a dentist.
3. Medical services furnished by an optometrist.
4. Certified nurse-midwife services.

5. APRN services in the office, client's home, or nursing facility.
6. Rural health clinic (RHC) encounters.
7. Federally qualified health center (FQHC) encounters.

B. Extensions of this benefit are considered when documentation verifies medical necessity. Refer to Sections 229.100 through 229.120 of the manual for procedures on obtaining extension of benefits for Primary Care Provider (PCP) services.

C. The Arkansas Medicaid Program exempts the following diagnoses from the extension of benefit requirements when the diagnosis is entered as the primary diagnosis:

1. Malignant neoplasm (**View ICD Codes.**).
2. HIV infection or AIDS (**View ICD Codes.**).
3. Renal failure (**View ICD Codes.**).
4. Pregnancy* (**View ICD Codes.**).
5. Opioid Use Disorder when treated with MAT (**View ICD OUD Codes.**)

When a Medicaid client's primary diagnosis is one (1) of those listed above and the client has exhausted the Medicaid established benefit for physician, APRN, and physician assistant services, outpatient hospital services, or laboratory and X-ray services, a request for extension of benefits is not required.

*OB ultrasounds and fetal non-stress tests are not exempt from Extension of Benefits. See Section 292.673 for additional coverage information.

257.000 Tobacco Cessation Products and Counseling Services 7-1-22

Tobacco cessation products either prescribed or initiated through statewide pharmacist protocol are available without Prior Authorization (PA) to eligible Medicaid clients. Additional information can be found on the **DHS Contracted Pharmacy Vendor website** or in the **Prescription Drug Program Prior Authorization Criteria**.

A. Providers may participate by prescribing covered tobacco cessation products. Reimbursement for tobacco cessation products is available for all prescription and over the counter (OTC) products and subject to be within U.S. Food and Drug Administration prescribing guidelines.

B. Counseling by the prescriber is required to obtain initial Prior Authorization (PA) coverage of the products. Counseling consists of reviewing the Public Health Service (PHS) guideline-based checklist with the client. The prescriber must retain the counseling checklist in the client records for audit. **View or print the Arkansas Be Well Referral Form.**

C. Counseling procedures do not count against the visit limits allowed per State Fiscal Year (SFY/July 1 to June 30), but they are limited to no more than two (2) 15 minute units and two (2) thirty minute units for a maximum allowable of four (4) units per SFY.

D. Counseling sessions can be billed in addition to an office visit or Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) visit. These sessions do not require a Primary Care Provider (PCP) referral.

E. If the client is under eighteen (18) years of age, and the parent or legal guardian smokes, the parent or legal guardian can be counseled as well, and the visit billed under the minor client's Medicaid number. The provider cannot prescribe medications for the parent or legal guardian under the minor client's Medicaid number. A parent or legal guardian session will count towards the four (4) counseling sessions limit described in Section C above.

F. Additional prescription benefits will be allowed per month for tobacco cessation products and will not be counted against the monthly prescription benefit limit. Tobacco cessation products are not subject to co-pay.

G. Arkansas Medicaid will provide coverage of prescription and over the counter (OTC) smoking/tobacco cessation covered outpatient drugs for pregnant women as recommended in "Treating Tobacco Use and Dependence - 2008 Update: A Clinical Practice Guideline" published by the Public Health Service in May 2008 or any subsequent modification of such guideline.

H. Refer to Section 292.900 for procedure codes and billing instructions.

292.740 Psychotherapy 7-1-22

The psychotherapy procedures covered under the Physician Program are allowed as a covered service when provided by the physician or when provided by a qualified practitioner who by State licensure is authorized to provide psychotherapy services.

Psychotherapy services must be provided by a physician or qualified practitioner rendering psychotherapy in the physician's office, the hospital, or the nursing home. Psychotherapy codes cannot be billed in conjunction with an office visit, a hospital visit or inpatient psychiatric facility visit and cannot be billed when services are performed in an outpatient behavioral health facility. Only one (1) psychotherapy visit per day is allowed in the physician's office, the hospital, or nursing home. Psychotherapy Services provided by a psychiatrist will count against the twelve (12) visits per State Fiscal Year service benefit limit. Record Review is not covered.

TOC required

171.100 PCP-Qualified Physicians, Advanced Practice Nurse Practitioners, and Single-Entity Providers 7-1-22

A. Primary Care Provider (PCP)-qualified physicians are those whose sole or primary specialty is

1. Family practice
2. General practice
3. Internal medicine
4. Pediatrics and adolescent medicine
5. Obstetrics and gynecology

B. Obstetricians and gynecologists may choose whether to be PCPs.

C. Physicians with multiple specialties may elect to enroll as PCPs if a secondary or tertiary specialty in their Medicaid provider file is listed in part A above.

D. All other PCP-qualified physicians and clinics must enroll as PCPs, except for those who certify in writing that they are employed exclusively by a University of Arkansas Medical School (UAMS) Regional Program, a federally qualified health center (FQHC), a Medical College Physicians Group, or a hospital (i.e., they are “hospitalists”, and they practice exclusively in a hospital).

E. Advanced practice registered nurses (APRN) licensed by the Arkansas State Board of Nursing may choose to enroll as PCPs.

F. PCP-qualified clinics and health centers (single-entity PCPs) are

1. UAMS Regional Programs
2. FQHCs
3. The family practice and internal medicine clinics at the University of Arkansas for Medical Sciences

171.630 Advanced Practice Registered Nurses and Physician Assistants in Rural Health Clinics (RHCs) 7-1-22

Advanced practice registered nurses (APRN) may function as Primary Care Providers at the performing provider level.

Licensed registered nurse practitioners (RNP) or licensed physician assistants (PA) employed by a Medicaid-enrolled rural health clinic (RHC) provider may not function as Primary Care Provider (PCP) substitutes, but they may provide primary care for a PCP’s enrollees, with certain restrictions.

A. The PCP affiliated with the RHC must issue a standing referral, authorizing primary care services to be furnished

1. To the PCP’s client enrollees
2. By registered nurse practitioners and physician assistants
3. In or on behalf of the RHC

B. Registered nurse practioners and physician assistants (PA) may not make referrals for medical services except for pharmacy services per established protocol.

C. The PCP must maintain a supervisory relationship with the registered nurse practitioners and physician assistants (PA).

218.100 RHC Encounter Benefit Limits 7-1-22

A. Medicaid clients under the age of twenty-one (21) in the Child Health Services (EPSDT) Program do not have a rural health clinic RHC encounter benefit limit.

B. A benefit limit of sixteen (16) encounters per state fiscal year (SFY), July 1 through June 30, has been established for clients twenty-one (21) years or older. The following services are counted toward the per SFY encounter benefit limit:

1. Provider visits in the office, client's home, or nursing facility;
2. Certified nurse-midwife visits;
3. RHC encounters;
4. Medical services provided by a dentist;
5. Medical services provided by an optometrist;
6. Advanced practice registered nurse (APRN) services in the office, client's home, or nursing facility; and
7. Federally qualified health center (FQHC) encounters.

Global obstetric fees are not counted against the service encounter limit. Itemized obstetric office visits are not counted in the limit.

The established benefit limit does not apply to individuals receiving Medication Assisted Treatment for Opioid Use Disorder when it is the primary diagnosis and rendered by a qualified X-DEA waivered provider. (**View ICD OUD Codes**).

Extensions of the benefit limit will be considered for services beyond the established benefit limit when documentation verifies medical necessity. Refer to Section 218.310 of this manual for procedures for obtaining extension of benefits.

218.300 Extension of Benefits 7-1-22

RHC encounters count toward the service benefit limits per state fiscal year. Arkansas Medicaid considers, upon written request, extending the RHC benefit for reasons of medical necessity.

A. Extensions of family planning benefits are not available.

B. Extensions of the RHC core service encounter benefit are automatic for certain diagnoses. The following diagnoses do not require a benefit extension request.

1. Malignant neoplasm **(View ICD codes.)**
2. HIV infection and AIDS **(View ICD codes.)**
3. Renal failure **(View ICD codes.)**

220.000 Benefit Limits 7-1-22

A. Arkansas Medicaid clients aged twenty-one (21) and older are limited to sixteen (16) FQHC core service encounters per state fiscal year (SFY, July 1 through June 30).

The following services are counted toward the sixteen (16) encounters per SFY benefit limit:

1. Federally Qualified Health Center (FQHC) encounters;
2. Physician visits in the office, patient's home, or nursing facility;
3. Certified nurse-midwife visits;
4. RHC encounters;
5. Medical services provided by a dentist;
6. Medical services provided by an optometrist; and
7. Advanced practice registered nurse services in the office, patient's home, or nursing facility.

B. The following services are not counted toward the sixteen (16) encounters per SFY benefit limit:

1. FQHC inpatient hospital visits do not count against the FQHC encounter benefit limit. Medicaid covers only one (1) FQHC inpatient hospital visit per Medicaid-covered inpatient day, for clients of all ages.
2. Obstetric and gynecologic procedures reported by CPT surgical procedure code do not count against the FQHC encounter benefit limit.
3. Family planning surgeries and encounters do not count against the FQHC encounter benefit limit.
4. Medication Assisted Treatment for Opioid Use Disorder does not count against the FQHC encounter limit when it is the primary diagnosis (**View ICD OUD Codes**) and rendered by a MAT specialty prescriber.

C. Medicaid clients under the age of twenty-one (21) in the Child Health Services (EPSDT) Program are not subject to an FQHC encounter benefit limit.

2.b. Rural Health Clinic Services

Rural health clinic services are limited to **sixteen (16) encounters** a year for **clients twenty-one (**21**) years of age** and older. This yearly limit is based on the State Fiscal Year (July I 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, certified nurse midwife services, **federally qualified health center encounters, and advanced practice registered nurse services,** or a combination of the seven.

Extensions **of the benefit limit** will be **available** if medically necessary. **Certain services, specified in the appropriate provider manual, are not counted toward the limit. Clients** under age **twenty-one (**2l**)** in the Child Health Services (EPSDT) Program are not benefit limited.

Rural **health clinic** core services are defined as follows:

1. Physicians' services, **advanced practice registered nurse's services**, and physician assistant s**ervices when properly supervised**;

2. Services and supplies furnished as an incident to professional services;

   Services and supplies "incident to" the professional services of physicians, physician assistants or **advanced practice registered** nurse**s** are those which are commonly furnished in connection with these professional services, are generally furnished in the **rural health center** 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.

3. Clinical psychologist services;

4. Clinical social worker services;

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2.b. Rural Health Clinic Services

5. Services of nurse midwives

6. Visiting nurse services on a part-time or intermittent basis to home-bound patients (limited to areas in which there is a shortage of home health agencies).

Rural health clinic ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the Rural **health clinic** offers such a service (e.g. dental, visual, etc.). The "other ambulatory services" that are provided by the Rural **health clinic** will count against the limit established in the plan for that service.

Medication Assisted Treatment visits do not count against the Rural Health Clinic encounter benefit limit when the visit is rendered by an X-DEA waivered provider as part of a Medication Assisted Treatment plan.

2.c. Federally **qualified health center** (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual (NCFA – Pub. 45-4).

Federally qualified health center services are limited to **sixteen (16)** encounters per **client,** per State Fiscal Year (July 1 through June 30) for clients **twenty-one** (21) **years or older. The applicable 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, certified nurse midwife services, rural health clinic encounters, and advanced practice registered nurse services, or a combination of the seven.**

For federally qualified health center core services beyond the **benefit** limit, extensions will be **available** if medically necessary. Beneficiaries under age **twenty-one** (21) in the Child Health Services (EPSDT) Program are not benefit limited.

FQHC hospital visits are limited to one (1) day of care for inpatient hospital covered days regardless of the number of hospital visits rendered. The hospital visits do not count against the FQHC encounter benefit limit.

Medication Assisted Treatment visits do not count against the FQHC encounter benefit limit when the visit is rendered by an X-DEA waivered provider as part of a Medication Assisted Treatment plan.

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.

4.d. (1) Face-to-Face Tobacco Cessation Counseling Services provided (by):

[X] (i) By or under supervision of a physician;

[X] (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services; * or

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time)

*describe if there are any limits on who can provide these counseling services

(2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

Provided: **[X]** No limitations **[ ]** With limitations*

*Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period (eight (8) per year) should be explained below.

Please describe any limitations:

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

(1) **For clients twenty-one (21) years of age or older, services provided in a physician's office, a patient's home, a nursing home, or elsewhere are limited to sixteen (16) visits per state fiscal year (SFY) (July 1 through June 30).**

(a) Benefit Limit Details

The benefit limit will be considered in conjunction with the benefit limit established for rural health clinic, federally qualified health center, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services and advanced practice registered nurse or a combination of the seven. Clients under age twenty-one (21) in the Child Health Services (EPSDT) Program are not benefit limited.

(b) Extension of Benefits

For physicians' services, medical services provided by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, **advanced practice registered nurse**, or rural health clinic core services beyond the benefit limit, extensions will be **available** if medically necessary.

(i) The following diagnoses are considered 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.

(c) Special Exceptions

(i) 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.

(**ii**) Surgical procedures **which** are generally considered to be elective require a **p**rior **a**uthorization from the Utilization Review Section.

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

– **(iv)** Organ transplants are covered as described in Attachment 3.1-E.

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 **client** under 21 years of age in the Child Health Services (EPSDT) Program. Extensions of the benefit limit will be **available** if medically necessary for **clients** 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) for **clients twenty-one (**21**) years or older**.

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, **Federally Qualified Health Center services**, certified nurse midwife services, and advanced practice **registered** nurse**s**, or a combination of the **seven**. For services beyond the **benefit** limit, extensions will be **available** if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the limit.

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 **clients** twenty-one (21) years or older. Services provided to **clients** under age **twenty-one (**21**)** in the Child Health Services (EPSDT) Program are not benefit limited.

(4) **Effective for dates of service on or after January 1, 2018, c**hiropractic services **do not** require a referral by the **client's** primary care **provider** (PCP).

d. Advanced **Practice Registered** Nurses **(APRN)**

For clients twenty-one (21) years of age or older, services provided in an advanced practice registered nurse's office, a patient's home, or nursing home are limited to sixteen (16) 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, **r**ural **h**ealth **c**linic, medical services furnished by a dentist, **office medical services furnished by an optometrist**, certified nurse midwife services and **federally qualified health center**, or a combination of the **seven**. For services beyond the **established benefit** limit, extensions will be **available** if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the limit. **Clients** in the Child Health Services (EPSDT) Program are not benefit limited.

2.b. Rural Health Clinic Services

Rural health clinic services are limited to **sixteen (16)** visits a year for **clients twenty-one** (21) **years or** older. This yearly limit is based on the State Fiscal Year (July I through June 30). **R**ural **h**ealth **c**linic **encounters will** be considered in conjunction with the benefit limit established for physician services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, **federally qualified health center encounters, and advanced practice registered nurse services, or a combination of the seven. Benefit limit** extensions will be **available** if medically necessary. **Certain services, specified in the appropriate provider manual, are not counted toward the service limit. Clients** under age **twenty-one (**2l**)** in the Child Health Services (EPSDT) Program are not benefit limited.

Rural **health clinic** core services are defined as follows:

1. Physicians' services, **advanced practice registered nurses' services**, and **services of** physician assistants **when provided under proper supervision;**

2. Services and supplies furnished as an incident to professional services;

   Services and supplies "incident to" the professional services of physicians, physician assistants, or **advanced practice registered** nurse**s**, are those which are commonly furnished in connection with these professional services, are generally furnished in the **rural health clinic** 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.

3. Clinical psychologist services;
4. Clinical social worker services;

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2.b. Rural Health Clinic Services

5. Services of nurse midwives; and

6. Visiting nurse services on a part-time or intermittent basis to home-bound patients (limited to areas in which there is a shortage of home health agencies).

Rural health clinic ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the **rural health clinic** offers such a service (e.g. dental, visual, etc.). The "other ambulatory services" that are provided by the **rural health clinic** will count against the limit established in the plan for that service.

Medication Assisted Treatment visits do not count against the Rural Health Clinic encounter benefit limit when the diagnosis is for opioid use disorder and is rendered by an X-DEA waivered provider as part of a Medication Assisted Treatment plan.

2.c. Federally **qualified health center** (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual) NCFA – Pub. 45-4).

Federally qualified health center services are limited to **sixteen (16)** encounters per **client**, per State Fiscal Year (July 1 through June 30) for **clients twenty-one** (21) **years or** older. **The applicable 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, certified nurse midwife services, rural health clinic encounters, and advanced practice registered nurse services, or a combination of the seven.**

Benefit extensions will be **available** if medically necessary. **Clients** under age **twenty-one** (21) in the Child Health Services (EPSDT) Program are not benefit limited.

FQHC hospital visits are limited to one (1) day of care for inpatient hospital covered days regardless of the number of hospital visits rendered. The hospital visits do not count against the FQHC encounter benefit limit.

Medication Assisted Treatment visits do not count against the FQHC encounter benefit limit when the diagnosis is for opioid use disorder and is rendered by an X-DEA waivered provider as part of a Medication Assisted Treatment plan.

4.c. Family Planning Services

(1) Comprehensive family planning services are limited to an original examination and up to three (3) follow-up visits annually. This limit is based on the state fiscal year (July 1 through June 30).

4.d. (1) Face-to-Face Tobacco Cessation Counseling Services provided (by):

[X] (i) By or under supervision of a physician;

[X] (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services; * or

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time)

***D**escribe if there are any limits on who can provide these counseling services

Arkansas Medicaid does not limit who can provide these counseling services at this time so long as they meet (ii) and (iii).

****Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12-month period (eight (8) per year) should be explained below.**

(2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

Provided: **[**x] No limitations [] With limitations*

*Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12-month period (eight (8) per year) should be explained below.

4.e. Prescription drugs for treatment of opioid use disorder

a. Oral preferred prescription drugs (preferred on the PDL) used for treatment of opioid use disorder require no prior authorization and do not count against the monthly prescription limits when prescribed by an X-DEA waivered provider as part of a Medication Assisted Treatment plan.

5. a. Physicians' Services

For clients twenty-one (21) years of age or older, services provided in a physician's office, a patient's home, or nursing home or elsewhere are limited to sixteen (16) visits per state fiscal year (July 1 through June 30).

The benefit limit will be in conjunction with the benefit limit established for advance practice registered nurse services, rural health clinic, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, and federally qualified health center, or a combination of the seven.

For services beyond the established visit limit, extensions will be available if medically necessary. Clients in the Child Health Services (EPSDT) Program are not benefit limited.

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

(2) Physicians' visits for pregnancy in the outpatient hospital are exempt from benefit extension requirements.

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

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

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

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

(7) Consultations**, including interactive consultations (telemedicine),** are limited to two (2) per recipient per year in a physician's office, **advanced practice registered nurse'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 **available** if medically necessary.

(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 **clients twenty-one (21) years or** older.

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 **clients** under **twenty-one (21)** years of age in the Child Health Services (EPSDT) Program. Extensions of the benefit limit will be **available** if medically necessary for **clients** 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) for **clients twenty-one (21) years or** over. 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, **federally qualified health center**, certified nurse midwife, and services provided by an advanced practice **registered** nurse, or a combination of the **seven**. For 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 ~~**twelve (12)**~~ **sixteen (16)** visit limit. Beneficiaries 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.

(4) **Effective for dates of service on or after January 1, 2018, c**hiropractic services **do not** require a referral by the **beneficiary's** primary care physician (PCP).

d. Advanced Practice Registered Nurses

For clients twenty-one (21) years of age or older, services provided in an advanced practice registered nurse's office, a patient's home, or nursing home are limited to sixteen (16) 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, rural health clinic, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, and federally qualified health center or a combination of the seven. For services beyond the established limit, extensions will be available if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the limit. Clients in the Child Health Services (EPSDT) Program are not benefit limited.