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211.100 Rural Health Clinic Core Services ~~10-13-0379-~~ 1-20

Rural Health Clinic core services are as follows:

A. Professional services that are performed by a physician at the clinic or are performed away from the clinic by a physician whose agreement with the clinic provides that he or she will be paid by the clinic for such services;

B. Services and supplies furnished "incident to" a physician's professional services;

C. Services provided by non-physician, services of physician assistants, nurse practitioners, nurse midwives, and specialized nurse practitioners when the provider is legally. ~~These non-physician professional services are covered when~~:

1. ~~Furnished by a nurse practitioner, physician assistant, nurse midwife or specialized nurse practitioner who is~~ employed by, or receivesing compensation from ~~the~~a rural health clinic;

2. ~~Furnished~~ under the medical supervision of a physician;

3. ~~Furnished~~ acting in accordance with any medical orders for the care and treatment of a patient prepared by a physician; and

4. ~~They are a type that the nurse practitioner, physician assistant, nurse midwife or specialized nurse practitioner who furnished the service is~~ acting within their scope of practice by providing services they are legally permitted to perform by the state in which the service is provided ~~and~~if

~~5.~~ ~~They~~the services would be covered if furnished by a physician;.

D. Services and supplies that are furnished as an incident to professional services furnished by a nurse practitioner, physician assistant, nurse midwife, or other specialized nurse practitioner; ~~and~~

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

~~1.~~ Note: **For purposes of visiting nurse care, a home-bound patient is one who is permanently or temporarily confined to his or her place of residence because of a medical or health condition. Institutions, such as a hospital or nursing care facility, are not considered a patient's residence.**

~~2.~~ Note: **A patient's place of residence is where he or she lives, unless he or she is in an institution such as a nursing facility, hospital, or intermediate care facility for individuals with intellectual disabilities (ICF/IID).; and**

F. Effective for dates of service on and after **July 1, 2020**, Medication Assisted Treatment (MAT) for Opioid Use Disorders is available to all qualifying Medicaid beneficiaries when provided by providers who possess an X-DEA license on file with Arkansas Medicaid Provider Enrollment for billing purposes. All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

218.100 RHC Encounter Benefit Limits ~~3-15-1079-~~ 1-20

A. There is no RHC encounter benefit limit for Medicaid beneficiaries under the age of twenty-one (21) in the Child Health Services (EPSDT) Program.

B. A benefit limit of twelve (12) visits per state fiscal year (SFY), July 1 through June 30, has been established for beneficiaries aged twenty-one (21) and older. The following services are counted toward the twelve (12) visits per SFY benefit limit:

1. Physician visits in the office, patient'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; and
6. Advanced nurse practitioner services.

Global obstetric fees are not counted against the 12-visit limit. Itemized obstetric office visits are 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 Codes**).

Field Code Changed

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.

252.400 Special Billing Procedures ~~10-4-13~~9-1-20

~~A Rural Health Center (RHC) must submit a claim that includes CPT code 87430, 87650, 87651, 87802 or 87880 in the Upper Respiratory Infection (URI)-Acute Pharyngitis episode if a strep test is performed when prescribing an antibiotic for beneficiaries. This allows DMS to determine if the Principle Accountable Provider (PAP) met or exceeded the quality threshold in order to qualify for a full positive supplemental payment for the URI-Pharyngitis episode.~~

252.401 Upper Respiratory Infection – Acute Pharyngitis 9-1-20

A Rural Health Center (RHC) must submit a claim that includes CPT code 87430, 87650, 87651, 87802, or 87880 in the Upper Respiratory Infection (URI)-Acute Pharyngitis episode if a strep test is performed when prescribing an antibiotic for beneficiaries. This allows DMS to determine if the Principle Accountable Provider (PAP) met or exceeded the quality threshold in order to qualify for a full positive supplemental payment for the URI-Pharyngitis episode.

252.402 Medication Assisted Treatment 9-1-20

When billing a claim for MAT the actual attending provider's NPI must be entered on the claim.

TOC required

212.220 Services Furnished in Collaboration with a Physician ~~10-13-039~~ 1-20

Nurse practitioner services are performed in collaboration with a physician or physicians.

A. Collaboration is a process in which a nurse practitioner works with one (1) or more physicians to deliver health care services within the scope of the practitioner's expertise, with medical direction, and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as provided by State law.

B. The collaborating physician does not need to be present with the nurse practitioner when the services are furnished or to make an independent evaluation of each patient who is seen by the nurse practitioner.

C. Medication Assisted Treatment (MAT) for Opioid Use Disorders: Effective dates of service on and after **July 1, 2020**, Medication Assisted Treatment for Opioid Use Disorders is available to all qualifying Medicaid beneficiaries when provided by providers who possess an X-DEA license on file with Arkansas Medicaid Provider Enrollment for billing purposes. All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

220.000 Benefit Limits ~~10-13-039~~ 1-20

A. Arkansas Medicaid beneficiaries aged twenty-one (21) and older are limited to twelve (12) FQHC core service encounters per state fiscal year (SFY, July 1 through June 30).

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 beneficiaries 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 Codes**) and rendered by a MAT specialty prescriber.

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

220.200 Extension of Benefits ~~10-1-169~~ 1-20

A. Extensions of family planning benefits are not available.

B. Extensions of the FQHC core service encounter benefit are automatic for the following diagnoses:

1. Malignant Neoplasm (**View ICD codes.**) Field Code Changed
2. HIV Infection and AIDS (**View ICD codes.**) Field Code Changed
3. Renal Failure (**View ICD codes.**) Field Code Changed
4. Opioid Use Disorder when treated with MAT (**View ICD codes**).

262.430 **Medication Assisted Treatment~~Reserved~~** ~~10-1-18~~9-1-20

When billing an encounter for (MAT) the actual rendering provider's NPI must be entered on the claim. If the billing provider's number is used, the claim will deny.

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272.501 **Medication Assisted Treatment and Opioid Use Disorder Treatment Drugs** ~~10-1-1879-~~ 1-20

Effective for dates of service on and after **July 1, 2020**, Medication Assisted Treatment for Opioid Use Disorders is available to all qualifying Medicaid beneficiaries when provided by providers who possess an X-DEA license on file with Arkansas Medicaid Provider Enrollment for billing purposes. All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

Effective for dates of services on and after **October 1, 2018**, the following Healthcare Common Procedure Coding System Level II (HCPCS) procedure codes are payable:

1~~A~~. **J2315** – Injection, naltrexone, depot form, 1 mg

2~~B~~. **J0570** – Buprenorphine implant, 74.2 mg

3~~C~~. **Q9991** – Injection, buprenorphine extended-release (Sublocade), less than or equal to 100 mg

4~~D~~. **Q9992** – Injection, buprenorphine extended-release (Sublocade), greater than 100 mg

To access prior approval of these HCPCS procedure codes when necessary, ~~reference~~ refer to the Pharmacy Memorandums, Criteria Documents and forms found at ~~dated August 30, 2018, via~~ the **DHS contracted Pharmacy vendor website**. ~~link below~~ **~~https://arkansas.magellanrx.com/provider/docs/provider_memos/ProvMem-20180830.pdf~~**

~~All other AR Medicaid billing requirements for drug procedure codes must be met in order for payment to be approved.~~

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252.448 Medication Assisted Treatment and Opioid ~~use~~ Use Disorder Treatment Drugs ~~10-1-1879-~~ 1-20

Effective for dates of service on and after **July 1, 2020**, Medication Assisted Treatment for Opioid Use Disorders is available to all qualifying Medicaid beneficiaries when provided by providers who possess an X-DEA license on file with Arkansas Medicaid Provider Enrollment for billing purposes. All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

Effective for dates of services on and after **October 1, 2018**, the following Healthcare Common Procedure Coding System Level II (HCPCS) procedure codes are payable:

~~A~~1. **J2315** – Injection, naltrexone, depot form, 1 mg

~~B~~2. **J0570** – Buprenorphine implant, 74.2 mg

~~C~~3. **Q9991** – Injection, buprenorphine extended-release (Sublocade), less than or equal to 100 mg

~~D~~4. **Q9992** – Injection, buprenorphine extended-release (Sublocade), greater than 100 mg

To access prior approval of these HCPCS procedure codes when necessary, ~~reference~~ refer to the Pharmacy Memorandums, Criteria Documents and forms found at the **DHS contracted Pharmacy vendor website**. ~~dated August 30, 2018, via the link below~~

~~**https://arkansas.magellanrx.com/provider/docs/provider_memos/ProvMem-20180830.pdf**~~

~~All other AR Medicaid billing requirements for drug procedure codes must be met in order for payment to be approved.~~

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211.200 **Staff Requirements** ~~3-1-199-1-~~ 20

Each Outpatient Behavioral Health Services provider must ensure that they employ staff which ~~is~~ are able and available to provide appropriate and adequate services offered by the provider. Behavioral Health staff members must provide services only within the scope of their individual licensure. The following chart lists the terminology used in this provider manual and explains the licensure, certification, and supervision that are required for each performing provider type.

PROVIDER TYPE	LICENSES	STATE CERTIFICATION REQUIRED	SUPERVISION
Independently Licensed Clinicians – Master's/Doctoral	Licensed Clinical Social Worker (LCSW) Licensed Marital and Family Therapist (LMFT) Licensed Psychologist (LP) Licensed Psychological Examiner – Independent (LPEI) Licensed Professional Counselor (LPC)	Yes, must be certified to provide services	Not Required
Independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	Licensed Clinical Social Worker (LCSW) Licensed Marital and Family Therapist (LMFT) Licensed Psychologist (LP) Licensed Psychological Examiner – Independent (LPEI) Licensed Professional Counselor (LPC)	Yes, must be certified to provide services	Not Required
Non-independently Licensed Clinicians – Master's/Doctoral	Licensed Master Social Worker (LMSW)	Yes, must be supervised by appropriate Independently Licensed	Required

PROVIDER TYPE	LICENSES	STATE CERTIFICATION REQUIRED	SUPERVISION
	Licensed Associate Marital and Family Therapist (LAMFT) Licensed Associate Counselor (LAC) Licensed Psychological Examiner (LPE) Provisionally Licensed Psychologist (PLP)	Clinician	
Non-independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	Licensed Master Social Worker (LMSW) Licensed Associate Counselor (LAC) Licensed Psychological Examiner (LPE) Provisionally Licensed Psychologist (PLP)	Yes, must be supervised by appropriate Independently Licensed Clinician and must be certified to provide services	Required
Advanced Practice Nurse (APN)	Adult Psychiatric Mental Health Clinical Nurse Specialist Child Psychiatric Mental Health Clinical Nurse Specialist Adult Psychiatric Mental Health APN Family Psychiatric Mental Health APN	No, must be part of a certified agency or have a Collaborative Agreement with a Physician	Collaborative Agreement with Physician Required
Physician	Doctor of Medicine (MD) Doctor of Osteopathic Medicine (DO)	No, must provide proof of licensure	Not Required

The services of a medical records librarian are required. The medical records librarian (or person performing the duties of the medical records librarian) shall be responsible for ongoing quality controls, for continuity of patient care, and patient traffic flow. The librarian shall assure that records are maintained, completed and preserved; that required indexes and registries are

maintained, and that statistical reports are prepared. This staff member will be personally responsible for ensuring that information on enrolled patients is immediately retrievable, establishing a central records index, and maintaining service records in such a manner as to enable a constant monitoring of continuity of care.

When an Outpatient Behavioral Health Services provider files a claim with Arkansas Medicaid, the staff member who actually performed the service must be identified on the claim as the rendering provider. This action is taken in compliance with the federal Improper Payments Information Act of 2002 (IPIA), Public Law 107-300, and the resulting Payment Error Rate Measurement (PERM) program initiated by the Centers for Medicare and Medicaid Services (CMS).

214.200 Medication Assisted Treatment and Opioid Use Disorder Treatment Drugs **9-1-20**

Effective for dates of service on and after July 1, 2020, Medication Assisted Treatment for Opioid Use Disorders is available to all qualifying Medicaid beneficiaries when provided by providers who possess an X-DEA license on file with Arkansas Medicaid Provider Enrollment for billing purposes. All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

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211.105- Coverage of Medication Assisted Treatment and Opioid Use Disorder Treatment Drugs **9-1-20**

Effective for claims with dates of service on or after **January 1, 2020**, coverage of preferred oral prescription drugs (preferred on the PDL) for opioid use disorder are available without prior authorization to eligible Medicaid beneficiaries. Products for other use disorders may still require PA. Additional criteria can be found at the **DHS contracted Pharmacy vendor's website**.

Coverage and Limitations

A. Reimbursement for preferred oral drugs is available with a valid prescription and compliance with the guidelines issued by the Substance Abuse and Mental Health Services Administration (SAMHSA) for eligible Medicaid beneficiaries. Additional SAMHSA information is available at **https://www.samhsa.gov/.**

B. Oral prescription drugs will not count against the monthly prescription benefit limit and are not subject to co-pay when used for a primary diagnosis of opioid use disorder.

C. Injectable opioid use disorder treatment drugs will require a prior authorization. The criteria can be found at the **DHS contracted Pharmacy vendor's website**.

D. FDA dosing and prescribing limitations apply.

213.100 Monthly Prescription Limits ~~**3-14-15**~~**9-1-20**

A. Each prescription for all Medicaid-eligible beneficiaries may be filled for up to a maximum 31 day ~~thirty-one day~~ supply. ~~Maintenance~~ medications for chronic illnesses must be prescribed and dispensed in quantities sufficient (not to exceed the maximum 31-day supply per prescription) to effect optimum economy in dispensing. For drugs that are specially packaged for therapy exceeding thirty-one (31) days, the days' supply limit (other than thirty-one (31)), as approved by the Agency, will be allowed for claims processing. Contact the Pharmacy Help Desk to inquire about specific days' supply limits on specially packaged dosage units.

View or print the contact information for the DHS contracted Pharmacy vendor.

~~**View or print the Magellan Pharmacy Help Desk contact information.**~~

B. Each Medicaid-eligible beneficiary age twenty-one (21) years and older is limited to three (3) Medicaid-paid prescriptions per calendar month.

Each prescription filled counts toward the monthly prescription limit except for the following:

1. Family planning items. This includes, but is not limited to, birth control pills, contraceptive foams, contraceptive sponges, suppositories, jellies, prophylactics, and diaphragms.
2. Prescriptions for Medicaid-eligible long-term care facility residents. (Prescriptions must be for Medicaid-covered drugs.)
3. Prescriptions for Medicaid-eligible beneficiaries under age twenty-one (21) in the Child Health Services/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. (Prescriptions must be for Medicaid-covered drugs.)

4. Prescriptions for opioid use disorder treatment when used according to SAMHSA guidelines.
5. Prescriptions for tobacco cessation products.

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201.500 Providers of Medication-Assisted Treatment (MAT) for Opioid Use Disorder 9-1-20

Providers of Medication-Assisted Treatment (MAT) for Opioid Use Disorder must be licensed in Arkansas and have a current X-DEA identification number on file with Arkansas Medicaid.

201.510 Providers of Medication-Assisted Treatment (MAT) for Opioid Use Disorder in Arkansas and Bordering States 9-1-20

Providers of MAT in Arkansas and the six (6) bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, and Texas) may be included as routine services providers if they meet all participation requirements for enrollment in Arkansas Medicaid and requirements outlined in Section 201.500.

Reimbursement may be available for MAT covered in the Arkansas Medicaid Program when treating Opioid Use Disorders. Claims must be filed according to the specifications in this manual. This includes assignment of ICD and HCPCS codes for all services rendered.

201.520 Providers of Medication-Assisted Treatment (MAT) for Opioid Use Disorder in States Not Bordering Arkansas 9-1-20

A. Providers in states not bordering Arkansas may enroll in the Arkansas Medicaid Program as limited services providers only after they have provided services to an Arkansas Medicaid eligible beneficiary and have a claim or claims to file with Arkansas Medicaid.

To enroll, a non-bordering state provider must download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application, contract, and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and Medicaid contract. **View or print the provider enrollment and contract package (Application Packet). View or print Provider Enrollment Unit contact information.**

B. Limited services providers remain enrolled for one (1) year.

1. If a limited services provider provides services to another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one (1) year past the most recent claim's last date of service, if the enrollment file is kept current.

2. During the enrollment period, the provider may file any subsequent claims directly to the Medicaid fiscal agent. Limited services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

203.270 Physician's Role in ~~Mental~~ Behavioral Health Services ~~9-15-12~~9-1-20

Medicaid covers ~~mental~~ behavioral health services when furnished by qualified providers to eligible Medicaid beneficiaries. A primary care physician referral is required for ~~most mental~~ some behavioral health services.

For additional information about services that may not require PCP referral, refer to Section 172.100 of this manual.

203.271 Medication-Assisted Treatment Provider Role for Administering Opioid Use Disorder Services 9-1-20

SAMHSA defines Medication Assisted Treatment (MAT) as the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of substance use disorders and can help some people to sustain recovery. This definition and other MAT guidelines can be found at the **SAMHSA website**.

Only providers who have met the requirements of Section 201.500 may prescribe medication required for the treatment of opioid use disorder for Arkansas Medicaid beneficiaries in conjunction with coordinating all follow-up and referrals for counseling and other services. This program applies only to prescribers of FDA-approved drugs for treatment of Opioid Use Disorder and will not be reimbursed for the practice of pain management.

~~**203.280 Physician's Role in the Rehabilitative Services for Persons with Mental Illness (RSPMI) Program** 10-13-03~~

~~The Medicaid Program covers a range of mental health rehabilitative or palliative services when provided to eligible Medicaid beneficiaries by a duly certified and Medicaid-enrolled Rehabilitative Services for Persons with Mental Illness (RSPMI). RSPMI must be prescribed by a physician and provided according to a written plan of care. RSPMI services are available only to outpatients.~~

225.000 Outpatient Hospital Benefit Limit ~~10-1-15~~9-1-20

Medicaid-eligible beneficiaries age twenty-one (21) and 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 (July 1 through June 30).

A. Outpatient hospital services include the following:

1. Non-emergency professional visits in the outpatient hospital and related physician services.
2. Outpatient hospital therapy and treatment services and related physician services.

B. Extension of benefits will be considered for patients 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 Codes.**)

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

E. All outpatient hospital services for beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program are not benefit limited.

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

225.100 Laboratory and X-Ray Services ~~10-1-159~~-1-20

The Medicaid Program's laboratory and X-ray services benefit limits apply to outpatient laboratory services, radiology services, and machine tests (such as electrocardiograms).

A. Medicaid has established a maximum paid amount (benefit limitation) of $500 per state fiscal year (July 1 through June 30) for beneficiaries aged twenty-one (21) and older, for outpatient laboratory and machine tests and outpatient radiology.

1. There is no lab and X-ray benefit limit for beneficiaries under age twenty-one (21).
2. There is no benefit limit on professional components of laboratory, X-ray, and machine tests for hospital inpatients.
3. There is no benefit limit on laboratory services related to family planning. See Section 292.552 for the family planning-related clinical laboratory procedures exempt from benefit limits.
4. There is no benefit limit on laboratory, X-ray, and machine-test services performed as emergency services.

B. Extension-of-benefit requests are considered for medically necessary services.

1. The claims processing system automatically overrides benefit limitations for services supported by the following diagnoses:
   a. Malignant neoplasm (**View ICD Codes.**)
   b. HIV infection and AIDS (**View ICD Codes.**)
   c. Renal failure (**View ICD Codes.**)
   d. Pregnancy (**View ICD Codes.**)
   e. Opioid Use Disorder when treated with MAT (**View ICD Codes.**) Designated lab tests will be automatically overridden when the diagnosis is Opioid Use Disorder. (**View Lab and Screening Codes.**)
2. Benefits may be extended for other conditions for documented reasons of medical necessity. Providers may request extensions of benefits according to instructions in Section 229.100 of this manual.

C. Magnetic resonance imaging (MRI) is exempt from the $500 outpatient laboratory and X-ray annual benefit limit. Medical necessity for each MRI must be documented in the beneficiary's medical record.

D. Cardiac catheterization procedures are exempt from the $500 annual benefit limit for outpatient laboratory and X-ray. Medical necessity for each procedure must be documented in the beneficiary's medical record.

226.000 Physician Services Benefit Limit ~~10-1-159~~-1-20

A. Physician services in a physician's office, patient's home, or nursing home for beneficiaries aged twenty-one (21) or older are limited to twelve (12) visits per state fiscal year (July 1 through June 30). Beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program are not subject to this benefit limit.

The following services are counted toward the twelve (12) visits per state fiscal year limit established for the Physician Program:

1. Physician services in the office, patient's home, or nursing facility.

2. Rural health clinic (RHC) encounters.
3. Medical services provided by a dentist.
4. Medical services furnished by an optometrist.
5. Certified nurse-midwife services.
6. Advanced nurse practitioner services.

B. Extensions of this benefit are considered when documentation verifies medical necessity. Refer to Sections 229.100 through 229.120 of this manual for procedures on obtaining extension of benefits for physician 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 Codes.**)

When a Medicaid beneficiary's primary diagnosis is one (1) of those listed above and the beneficiary has exhausted the Medicaid established benefit for physician 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.

230.000 Medication-Assisted Treatment for Opioid Use Disorder **9-1-20**

A. MAT is covered for eligible Medicaid beneficiaries who have an Opioid Use Disorder when diagnosis and clinical impression is determined in the terminology of ICD.

B. Providers are required to follow SAMHSA guidelines for the full provision of MAT.

C. Providers are encouraged to use telemedicine services when in-person treatment is not readily accessible.

D. In accordance with SAMHSA guidelines, MAT requires at a minimum:

a. **Initial evaluation and diagnosis of Opioid Use Disorder, including:**

i. Drug screening tests to accompany proper medication prescribing for MAT. Buprenorphine mono-therapy is typically reserved only for pregnant women and those with a documented anaphylactic reaction to other MAT medications like Buprenorphine/Naloxone combinations.

ii. Lab screening tests for communicable diseases, as appropriate based on the patient's history.

iii. Use of all necessary consent forms for treatment and HIPAA compliant communication.

iv. Execution of a Treatment Agreement or Contract such as SAMHSA's sample treatment agreement found under Tip 63 on the SAMHSA website: **https://www.samhsa.gov/search_results?k=Opioid+Use+Disorder.** Providers may develop their own agreement or contract as long as it contains all elements listed within SAMHSA's sample agreement.

v. Development of a Person-Centered Treatment Plan.

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vi. Referral for independent clinical counseling or documented plan for integrated follow-up visit including counseling.

vii. Identification of a MAT team member to function as the case manager to offer support services.

b. **Continuing Treatment (first year):**

i. Regular outreach to the patient to determine need for assistance in accessing resources, providing information on available programs and supports in the community, and referrals as needed to other practitioners.

ii. At least one (1) follow-up MAT office visit per month for medication and treatment management.

iii. Drug testing in conjunction with each monthly visit.

iv. At least one (1) independent clinical counseling visit or documented plan for integrated follow-up visit including counseling per month.

c. **Maintenance Treatment (subsequent years)**

i. Regular outreach to the patient to determine need for assistance in accessing resources, providing information on available programs and supports in the community, and referrals as needed to other practitioners.

ii. At least one (1) follow-up MAT office visit quarterly for medication and treatment management.

iii. Drug testing in conjunction with each quarterly visit.

iv. At least one (1) independent clinical counseling visit or documented plan for integrated follow-up visit including counseling at an amount and duration medically necessary for continued recovery.

230.100 Compliance with SAMHSA Guidelines **9-1-20**

Arkansas Medicaid or its designated authority will periodically review claims for MAT to ensure provider compliance with minimum requirements set forth in this manual and with the SAMHSA guidelines that are current as of the date of services. Failure to comply with minimum requirements for the program may result in recoupment or other sanctions outlined in Section I of the Arkansas Medicaid Provider Manual.

MAT providers are expected to adhere to the SAMHSA guidelines when providing MAT. We understand MAT providers may not be able to control all elements of treatment when referred and provided by other practitioners. However, to ensure the effectiveness of the program, the MAT provider is responsible for case management and adjusting the treatment plan for the beneficiary's maximum progress. Documentation regarding how the MAT provider is monitoring and addressing non-compliance will be reviewed. For example, when a client routinely misses office visits or referred counseling appointments or is otherwise not following the MAT program, the client should be appropriately tapered off medication if necessary. In the patient/prescriber agreement, the provider would set out those expectations in accordance with SAMHSA guidelines. If counseling or other components of treatment are being referred, those providers' records are also subject to post payment review and recoupment for services not documented as compliant with SAMHSA guidelines.

263.000 Prescription Drug Prior Authorization ~~10-1-18~~ **9-1-20**

Prescription drugs are available for reimbursement under the Arkansas Medicaid Program when prescribed by a ~~physician~~ provider with prescriptive authority. Certain prescription drugs may require prior authorization. It is the responsibility of the prescriber to request and obtain the prior authorization. Refer to the **DHS contracted Pharmacy vendor's website** ~~website at https://medicaid.mmis.arkansas.gov/~~ for the following information:

A. Prescription drugs requiring prior authorization.

B. Criteria for drugs requiring prior authorization.

C. Forms to be completed for prior authorization.

D. Procedures required of the prescriber to request and obtain prior authorization.

E. Effective for dates of services on and after **October 1, 2018**, the following Healthcare Common Procedure Coding System Level II (HCPCS) procedure codes are payable:

1. **J2315** – Injection, naltrexone, depot form, 1 mg
2. **J0570** – Buprenorphine implant, 74.2 mg
3. **Q9991** – Injection, buprenorphine extended-release (Sublocade), less than or equal to 100 mg
4. **Q9992** – Injection, buprenorphine extended-release (Sublocade), greater than 100 mg

To access prior approval of these HCPCS procedure codes when necessary, reference the Pharmacy Memorandums, Criteria Documents and forms found at the **DHS contracted Pharmacy vendor's website**. ~~dated August 30, 2018, via the link below https://arkansas.magellanrx.com/provider/docs/provider_memos/ProvMem-20180830.pdf~~

263.100 Coverage of Oral Drugs Used for Opioid Use Treatment ~~19~~-1-20

Effective for claims with dates of service on or after **January 1, 2020**, coverage of preferred oral prescription drugs (preferred on the PDL) for opioid use disorder and tobacco cessation are available without prior authorization to eligible Medicaid beneficiaries. Products for other use disorders may still require PA. Additional criteria can be found at the **DHS contracted Pharmacy vendor's website.**

Coverage and Limitations

A. Reimbursement for preferred oral drugs is available with a valid prescription and compliance with the guidelines issued by the Substance Abuse and Mental Health Services Administration (SAMHSA) for eligible Medicaid beneficiaries. Additional SAMHSA information is available at **https://www.samhsa.gov/.**

B. Prescription drugs for treatment of opioid use disorder will not count against the monthly prescription benefit limit and are not subject to co-pay.

C. Injectable products will require a prior authorization. The criteria can be found at the **DHS contracted Pharmacy vendor's website.**

D. FDA dosing and prescribing limitations apply.

272.600 Medication Assisted Treatment for Opioid Use Disorder 9-1-20

Participating MAT providers must bill all components related to MAT guidelines, including but not limited to office visits, lab screening and testing, and required counseling if not referred to another provider.

When a MAT provider meets all conditions outlined within Section 230.000 within the same day, an inclusive payment method may be available for billing the required services (with the exception of lab testing).

When proper treatment according to these guidelines cannot be accomplished within the same day or must encompass referrals for counseling, each provider must bill separately for the actual services he or she provided according to regular fee-for-service billing rules. See Section 292.920 for special billing procedures.

MARKUP

292.920 Medication Assisted Treatment (MAT) for Opioid Use Disorder 9-1-20

There are two (2) methods of billing for MAT.

1. Method 1- Inclusive Rate

   a. The inclusive method of billing shall be used when all SAMHSA guideline services as set forth at a minimum in Section 230.000 are provided on the same date of service by the same billing group who has at least one (1) performing provider with an X-DEA number on file with Arkansas Medicaid.

      i. For new patients, the provider group shall use HCPCS code H0001, modifier X2 and list an Opioid Use Disorder ICD-10 code as primary. The performing provider must be enrolled as a MAT provider and the claim will pay a single rate for all services (Office Visit, counseling, case management, medication induction/maintenance, etc). Drug and lab testing/screening will continue to be billed separately, using an X2 modifier with the proper code for the test or screen.

      ii. For established patients requiring continuing follow-up MAT treatment, the provider group shall use HCPCS code H0001, modifiers U8, X2, and list an Opioid Use Disorder ICD-10 code as primary. The performing provider must be enrolled as a MAT provider and the claim will pay a single rate for all follow-up services as indicated on the treatment plan and set forth at a minimum in Section 230.000 (Office Visit, counseling and medication induction/maintenance, etc). Drug and lab testing/screening will continue to be billed separately, using an X2 modifier with the proper code for the test or screen.

      iii. For established patients requiring maintenance follow-up MAT treatment, the provider group shall use HCPCS code H0001, modifiers U8, X4, and list an Opioid Use Disorder ICD-10 code as primary. The performing provider must be enrolled as a MAT provider and the claim will pay a single rate for all follow-up services as indicated on the treatment plan and set forth at a minimum in Section 230.000 (Office Visit, counseling and medication induction/maintenance, etc). Drug and lab testing/screening will continue to be billed separately, using an X4 modifier with the proper code for the test or screen.

      iv. The specific HCPCS code and modifiers found in the following link are required for billing the inclusive rate. **View or print the procedure codes and modifiers for MAT services.**

2. Method 2 – Regular Fee-for-Service Rates

   a. The regular Fee-for-Service method of billing shall be used when all SAMHSA guideline services as set forth at a minimum in Section 230.000 cannot be provided on the same date of service, or cannot be provided by the same billing group who has the MAT specialized performing provider; therefore, causing some SAMHSA guideline services to be referred elsewhere.

      i. For new patients, the MAT provider shall use the appropriate E & M (office visit) code, add modifier X2, and list an Opioid Use Disorder ICD-10 code as primary. The provider shall use the proper Lab and Urine Screening codes plus the additional X2 modifier for the screenings required.

      ii. For established patients requiring continuing treatment, the MAT provider shall use the appropriate E & M (office visit) code, add modifier X2, and list an Opioid Use Disorder ICD-10 code as primary. The provider shall use the proper Lab and Urine Screening codes plus the additional X2 modifier for the screenings required.

      iii. For established patients requiring maintenance treatment, the MAT provider

shall use the appropriate E & M (office visit) code, add modifier X4, and list an Opioid Use Disorder ICD-10 code as primary. The provider shall use the proper Lab and Urine Screening codes plus the additional X4 modifier for the screenings required.

Allowable ICD-10 codes for Opioid Use Disorder may be found here: **(SEE OUD CODES)**

Allowable lab and screening codes may be found here: **(SEE LAB CODES)**

Providers utilizing telemedicine, regardless of Method, shall adhere to telemedicine rules listed in Sections 105.190 and 305.000 in addition to those above. The provider at the distance site shall use both the GT modifier and the X2 or X4 modifier on the service claim.

MARK-UP

172.100 **Services not Requiring a PCP Referral** ~~12-1-19~~9-1-20

The services listed in this section do not require a PCP referral~~.~~:

A. Adult Developmental Day Treatment (ADDT) core services;

B. ARChoices waiver services;

C. Anesthesia services, excluding outpatient pain management;

D. Assessment (including the physician's assessment) in the emergency department of an acute care hospital to determine whether an emergency condition exists. The physician and facility assessment services do not require a PCP referral (if the Medicaid beneficiary is enrolled with a PCP);

E. Chiropractic ~~Services~~services;

F. Dental services;

G. Developmental Disabilities Services Community and Employment Support;

H. Disease control services for communicable diseases, including testing for and treating sexually transmitted diseases such as HIV/AIDS;

I. Emergency services in an acute care hospital emergency department, including emergency physician services;

J. Family Planning services;

K. Gynecological care;

L. Inpatient hospital admissions on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment;

M. Mental health services, as follows:

1. Psychiatry for services provided by a psychiatrist enrolled in Arkansas Medicaid and practicing as an individual practitioner~~.~~

2. Medication Assisted Treatment for Opioid Use Disorder when rendered by an X-DEA waivered practitioner

3~~2~~. Rehabilitative Services for Youth and Children (RSYC) Program~~.~~

N. Obstetric (antepartum, delivery, and postpartum) services~~.~~

1. Only obstetric-gynecologic services are exempt from the PCP referral requirement~~.~~

2. The obstetrician or the PCP may order home health care for antepartum or postpartum complications~~.~~

3. The PCP must perform non-obstetric, non-gynecologic medical services for a pregnant woman or refer her to an appropriate provider~~.~~

O. Nursing facility services and intermediate care facility for individuals with intellectual disabilities (ICF/IID) services;

P. Ophthalmology services, including eye examinations, eyeglasses, and the treatment of diseases and conditions of the eye;

Q. Optometry services;

R. Pharmacy services;

S. Physician services for inpatients in an acute care hospital, including. ~~This includes:~~

~~1.~~ ~~D~~direct patient care (initial and subsequent evaluation and management services, surgery, etc.), and

~~2.~~ ~~i~~indirect care (pathology, interpretation of X-rays, etc.);

T. Hospital non-emergency or outpatient clinic services on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment;

U. Physician visits (except consultations, which do require PCP referral) in the outpatient departments of acute care hospitals: but

~~1.~~ ~~Medicaid will cover these services without a PCP referral~~ only if the Medicaid beneficiary is enrolled with a PCP and the services are within applicable benefit limitations;

~~2. Consultations require PCP referral.~~

V. Professional components of diagnostic laboratory, radiology, and machine tests in the outpatient departments of acute care hospitals, but only if. ~~Medicaid covers these services without a PCP referral only:~~

~~1.~~ ~~I~~if the Medicaid beneficiary is enrolled with a PCP and

~~2.~~ ~~T~~the services are within applicable benefit limitations;

W. Targeted Case Management services provided by the Division of Youth Services or the Division of Children and Family Services under an inter-agency agreement with the Division of Medical Services;

X. Transportation (emergency and non-emergency) to Medicaid-covered services; and

Y. Other services, such as sexual abuse examinations, when the Medicaid Program determines that restricting access to care would be detrimental to the patient's welfare or to program integrity, or would create unnecessary hardship.

MARK-UP

2.a. Outpatient Hospital Services (Continued)

Non-Emergency Services

Outpatient hospital services other than those which qualify as emergency, outpatient surgical procedures and treatment, and therapy services are covered as non-emergency services.

Benefit Limit

Outpatient hospital services are limited to a total of twelve (12) visits a year. This yearly limit is based on the State Fiscal Year - July 1 through June 30. Outpatient hospital services include the following:

- non-emergency outpatient hospital and related physician and nurse practitioner services; and
- outpatient hospital therapy and treatment services and related physician and nurse practitioner services.

For services beyond the 12-visit limit, an extension of benefits will be provided if medically necessary. The following diagnoses are ~~considered to be~~ categorically medically necessary and do not require prior authorization for medical necessity: Malignant neoplasm; HIV infection; renal failure; **opioid use disorder;** ~~-~~and pregnancy. All other diagnoses are subject to prior authorization before benefits can be extended.

Outpatient hospital services are not benefit limited for recipients in the Child Health Services (EPSDT) Program.

2.b. Rural Health Clinic Services

5. Services of physician assistants, nurse practitioners, nurse midwives, and specialized nurse practitioners;

6. Services and supplies furnished as an incident to a nurse practitioner's or physician assistant's services; and

7. 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.

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).

Effective for claims with dates of service on or after July 1, 1995, federally qualified health center (FQHC) services are limited to twelve (12) encounters per beneficiary, per State Fiscal Year (July 1 through June 30) for beneficiaries age **twenty-one** (21) and older. For federally qualified health center core services beyond the 12-visit limit, extensions will be provided 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.

CATEGORICALLY NEEDY

3. Other Laboratory and X-Ray Services

~~(1)~~ Other **medically necessary** laboratory and X-ray services **are covered** when ordered and provided ~~by or~~ under the direction of a physician or other licensed practitioner of the healing arts within the scope of his **or** /her practice, as defined by State law in the practitioner's office or outpatient hospital setting or by a certified independent laboratory which meets the requirements for participation in Title XVIII. ~~-~~**Services are limited to five hundred dollars ($500) per State Fiscal Year (July 1 – June 30), unless specifically exempted from the limit.** ~~For services above $500.00 per State Fiscal Year for recipients age 21 and older, an extension will be provided if medically necessary.~~**Extensions of the benefit limit for recipients age twenty-one (21) or older will be provided through prior authorization, if medically necessary. The five hundred dollars ($500) per State Fiscal Year benefit limit does not apply to services provided to recipients under age twenty-one (21) enrolled in the Child Health Services (EPSDT) Program.**

(1) The following diagnoses ~~are considered to beare~~ **specifically exempted from the five hundred dollars ($500) ~~$500~~ per State Fiscal Year laboratory and X-ray services health benefit limit:** ~~categorically medically necessary and do not require prior authorization for medical necessity:~~ Malignant neoplasm; HIV infection; and renal failure. **The cost of related laboratory and X-rayx-ray services will not be included in the calculation of the recipient's five hundred dollars ($500) ~~$500~~ laboratory and X-ray services health benefit limit.** ~~All other diagnoses are subject to prior authorization before benefits can be extended.~~ **Drug screening will be specifically exempt from the five hundred dollars ($500) $500 per State Fiscal Year laboratory and X-ray services health benefit limit when the diagnosis is for opioid use disorder and the screening is ordered by an X-DEA waivered provider as part of a Medication Assisted Treatment plan. The cost of these screenings will not be included in the calculation of the recipient's five hundred dollars ($500) ~~$500~~ laboratory and X-ray services health benefit limit.**

(2) Magnetic Resonance Imaging (MRI) and Cardiac Catheterization procedures are **specifically exempted from to the five hundred dollars ($500) ~~$500~~ per State Fiscal Year laboratory and X-ray services health benefit limit. The cost of these procedures will not be included in the calculation of the recipient's five hundred dollars ($500) $500 laboratory and X-ray services health benefit limit.** ~~exempt from the extension procedures.~~

(3) Portable X-Ray Services are **subject to the five hundred dollars ($500) ~~$500~~ benefit limit. Extensions of the benefit limit for recipients age twenty-one (21) or older will be provided through prior authorization, if medically necessary. Services may be provided to an eligible recipient in his or /her place of residence upon the written order of the recipient's physician. Services are limited to the following:**

~~a. limited to the following:~~

~~b.~~

Sskeletal films ~~involving~~ **which involve** arms and legs, pelvis, vertebral column, and skull;

a.

~~c.~~ Cchest films which do not involve the use of contrast media; and

b.

~~d.~~c. Aabdominal films which do not involve the use of contrast media.

~~Services may be provided to an eligible recipient in his/her place of residence upon the written order of the recipient's physician.~~

~~Portable X-ray services are included in the extension procedures.~~

_____(4) **Two (2) chiropractic X-rays are covered per state fiscal year. Chiropractic~~or~~ X-Ray Services are subject to the five hundred dollars ($500) ~~$500~~ benefit limit. ~~Extensions~~ of the benefit limit for recipients age twenty-one (21) or older will be provided through prior authorization, if medically necessary.**

~~X-ray is limited to two (2) per State Fiscal Year (July 1 through June 30).~~

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 twenty-one (21) or older may have up to six (6) prescriptions each month under the program. The first three (3) prescriptions do not require prior authorization. The three (3) additional prescriptions must be prior authorized. Family Planning, tobacco cessation, ~~,~~ **oral prescription drugs for opioid use disorder when used according to the SUPPORT for Patients and Communities Act and SAMHSA guidelines**, and EPSDT prescriptions do not count against the prescription limit.

(2) Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

(3) The Medicaid agency provides coverage, to the same extent that it provides coverage for all Medicaid recipients, for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses – with the exception of those covered by Part D plans as supplemental benefits through enhanced alternative coverage as provided in 42 C.F.R. §423.104 (f) (1) (ii) (A) – to full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D.

The following excluded drugs, set forth on the Arkansas Medicaid Pharmacy Vendor's Website ~~(https://arkansas.magellanrx.com/provider/documents/www.medicaid.state.ar.us/InternetSolution/Provider/pharm/scripinfo.aspx#1927d)~~, are covered:

a. select agents when used for weight gain:
   Androgenic Agents;
b. select agents when used for the symptomatic relief of cough and colds:
   Antitussives; Antitussive-Decongestants; and Antitussive-Expectorants;
c. select prescription vitamins and mineral products, except prenatal vitamins and fluoride:
   B 12; Folic Acid~~;~~ and Vitamin K;
d. select nonprescription drugs:
   Antiarthritics; Antibacterials and Antiseptics; Antitussives; Antitussives-Expectorants; Analgesics; Antipyretics; Antacids; Antihistamines; Antihistamine-Decongestants; Antiemetic/Vertigo Agents; Gastrointestinal Agents; Hematinics; Laxatives; Opthalmic Agents; Sympathomimetics; Topical Antibiotics; Topical Antifungals; Topical Antiparasitics; and Vaginal Antifungals; and
e. non-prescription products for smoking cessation.

(4) 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 seventy-two (72) hour supply of drugs in emergency situations.

State/Territory: ARKANSAS

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S):

4.d. Tobacco cessation counseling services for pregnant women

☒ Provided: ☐ No limitations ☒ with limitations*

e. Medication-Assisted Treatment for opioid use disorders

☒ Provided: ☐ No limitations ☒ with limitations*

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

☒ Provided: ☐ No limitations ☒ with limitations*

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

☒ Provided: ☐ No limitations ☒ with limitations*

*Description provided on attachment.

2.a. Outpatient Hospital Services (Continued)

Non-Emergency Services

Outpatient hospital services other than those which qualify as emergency, outpatient surgical procedures and treatment, and therapy services are covered as non-emergency services.

Benefit Limit

Outpatient hospital services are limited to a total of twelve (12) visits a year. This yearly limit is based on the State Fiscal Year - July 1 through June 30. Outpatient hospital services include the following:

- non-emergency outpatient hospital and related physician and nurse practitioner services; and
- outpatient hospital therapy and treatment services and related physician and nurse practitioner services.

For services beyond the 12-visit limit, an extension of benefits will be provided if medically necessary. The following diagnoses are considered ~~to be~~ categorically medically necessary and do not require prior authorization for medical necessity: Malignant neoplasm; HIV infection; renal failure; **opioid use disorder when the visit is rendered by an X-DEA waivered provider as part of a Medication Assisted Treatment plan,** and pregnancy. All other diagnoses are subject to prior authorization before benefits can be extended.

Outpatient hospital services are not benefit limited for recipients in the Child Health Services (EPSDT) Program.

MARK UP

2.b. Rural Health Clinic Services

5. Services of physician assistants, nurse practitioners; nurse midwives; and specialized nurse practitioners;

6. Services and supplies furnished as an incident to a nurse practitioner's or physician assistant's services; and

7. 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).

Effective for claims with dates of service on or after July 1, 1995, federally qualified health center (FQHC) services are limited to twelve (12) encounters per beneficiary, per State Fiscal Year (July 1 through June 30) for beneficiaries age **twenty-one** (21) and older. For federally qualified health center core services beyond the 12-visit limit, extensions will be provided 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.

MARKUP

3. Other Laboratory and X-Ray Services

~~(1)~~ Other **medically necessary** laboratory and X-ray services **are covered** when ordered and provided ~~by or~~ under the direction of a physician or other licensed practitioner of the healing arts within the scope of his/ **or** her practice as defined by State law in the practitioner's office or outpatient hospital setting or by a certified independent laboratory which meets the requirements for participation in Title XVIII. ~~For s~~Services **are limited to** ~~above $500~~**five hundred dollars ($500)** ~~.00~~ per State Fiscal Year **(July 1-June 30), unless specifically exempt from the limit. Extensions of the benefit limit** for recipients age **twenty-one** (21) ~~and~~**or** older~~, an extension~~ will be provided **through prior authorization**, if medically necessary.~~: The following diagnoses are considered to be categorically medically necessary and do not require prior authorization for medical necessity: Malignant neoplasm; HIV infection and renal failure. All other diagnoses are subject to prior authorization before benefits can be extended.~~**The $500five hundred dollars ($500) per State Fiscal Year benefit limit does not apply to services provided to recipients under age twenty-one (21) enrolled in the Child Health Services (EPSDT) Program.**

~~The extension procedures do not apply for services provided to recipients under age 21 in the Child Health Services (EPSDT) Program.~~

~~(2) Magnetic Resonance Imaging (MRI) and Cardiac Catheterization procedures are exempt from the extension procedures.~~

~~(3) Portable X-Ray Services~~

~~Services are limited to the following:~~

~~skeletal films involving arms and legs, pelvis, vertebral column and skull;~~
~~chest films which do not involve the use of contrast media; and~~
~~abdominal films which do not involve the use of contrast media.~~

~~Services may be provided to an eligible recipient in his/her place of residence upon the written order of the recipient's physician.~~

~~Portable X-ray services are included in the extension procedures.~~

~~(4) Chiropractor X-Ray Services~~

~~X-ray is limited to two (2) per State Fiscal Year (July 1 through June 30).~~

The following diagnoses are specifically exempt from the ~~$500~~five hundred dollars ($500) per State Fiscal Year laboratory and X-ray services health benefit limit: Malignant neoplasm; HIV infection; and renal failure. The cost of related laboratory and X-ray services will not be

included in the calculation of the recipient's ~~$500~~five hundred dollars ($500) laboratory and X-ray services health benefit limit.

(1) Drug screening will be specifically exempt from the ~~$500~~five hundred dollars ($500) per State Fiscal Year laboratory and X-ray services health benefit limit when the diagnosis is for opioid use disorder and the screening is ordered by ~~a Medication Assisted Treatment waiver~~an X-DEA waivered provider as part of a MAT treatment plan. The cost of these screenings will not be included in the calculation of the recipient's ~~$500~~five hundred dollars ($500) laboratory and X-ray services health benefit limit.

(2) Magnetic Resonance Imaging (MRI) and Cardiac Catheterization procedures are specifically exempt from the ~~$500~~five hundred dollars ($500) per State Fiscal Year outpatient laboratory and X-ray services health benefit limit. The cost of these procedures will not be included in the calculation of the recipient's ~~$500~~five hundred dollars ($500) laboratory and X-ray services health benefit limit.

(3) Portable X-Ray Services are subject to the ~~$500~~five hundred dollars ($500) benefit limit. Extensions of the benefit limit for recipients age twenty-one (21) or older will be provided through prior authorization, if medically necessary. Services may be provided to an eligible recipient in his or her place of residence upon the written order of the recipient's physician. Services are limited to the following:

a. Skeletal films which involve arms and legs, pelvis, vertebral column, and skull;

b. Chest films which do not involve the use of contrast media; and

c. Abdominal films which do not involve the use of contrast media.

(4) Two (2) chiropractic X-rays are covered per state fiscal year. Chiropractic X-Ray Services are subject to the ~~$500~~five hundred dollars ($500) benefit limit. Extensions of the benefit limit for recipients age twenty-one (21) or older will be provided through prior authorization, if medically necessary.

4.a. Nursing Facility Services - Not Provided

MEDICALLY NEEDY

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)

*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: ☐ No limitations [X] 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:

Face-to-face tobacco cessation counseling services are limited to no more than two (2) 15-minute units and two (2) 30-minute units for a maximum allowable of four (4) units per state fiscal year.

4.e. Prescription drugs for treatment of opioid use disorder when provided by an X-DEA waivered practitioner.

a. Oral preferred p~~P~~rescription 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 used according to the SUPPORT for Patients and Communities Act and Substance Abuse and Mental Health Service Administration (SAMHSA) guidelines.

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

MARKUP

(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 twenty-one (21) and older.

MARK UP

MEDICALLY NEEDY

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 twenty-one (21) or older may have up to six (6) prescriptions each month under the program. The first three (3) prescriptions do not require prior authorization. The three (3) additional prescriptions must be prior authorized. Family Planning, tobacco cessation, oral prescription drugs for opioid use disorder when used according to the SUPPORT for Patients and Communities Act and SAMHSA guidelines, and EPSDT prescriptions do not count against the prescription limit.

(2) Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

(3) The Medicaid agency provides coverage, to the same extent that it provides coverage for all Medicaid recipients, for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses – with the exception of those covered by Part D plans as supplemental benefits through enhanced alternative coverage as provided in 42 C.F.R. §423.104 (f) (1) (ii) (A) – to full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D.

The following excluded drugs, set forth on the Arkansas Medicaid Pharmacy Vendor's Website (~~https://arkansas.magellanrx.com/provider/documents/www.medicaid.state.ar.us/InternetSolution/Provider/pharm/scripinfo.aspx#1927d~~), are covered:

a. select agents when used for weight gain:
Androgenic Agents;
b. select agents when used for the symptomatic relief of cough and colds:
Antitussives; Antitussive-Decongestants; and Antitussive-Expectorants;
c. select prescription vitamins and mineral products, except prenatal vitamins and fluoride:
B 12; Folic Acid; and Vitamin K;
d. select nonprescription drugs:
Antiarthritics; Antibacterials and Antiseptics; Antitussives; Antitussives-Expectorants; Analgesics; Antipyretics; Antacids; Antihistamines; Antihistamine-Decongestants; Antiemetic/Vertigo Agents; Gastrointestinal Agents; Hematinics; Laxatives; Opthalmic Agents; Sympathomimetics; Topical Antibiotics; Topical Antifungals; Topical Antiparasitics; and Vaginal Antifungals; and
e. non-prescription products for smoking cessation.

(4) 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.

Citation	Condition or Requirement

1. Describe any additional circumstances of "cause" for disenrollment (if any).

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 42 CFR 438.50
42 CFR 438.10

X The state assures that its state plan program ~~complies~~is ~~in compliance~~ with 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

The following PCCM exempt services do not require PCP authorization:
Dental Services
Emergency hospital care
DDS Community and Employment Support
Family Planning
Anesthesia
Alternative Waiver Programs
Adult Developmental Day Treatment Services (ADDT) Core Services only
Disease Control Services for Communicable Diseases
ARChoices waiver services
Gynecological care
Inpatient Hospital admissions on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment
Medication-Assisted Treatment Services for opioid use disorder when rendered by X-DEA waiver exempt providers
Mental health services as follows:

a. Psychiatry for services provided by a psychiatrist enrolled in Arkansas Medicaid and practice as an individual practitioner
b. Rehabilitative Services for Youth and Children

Nurse Midwife services
ICF/IID Services
Nursing Facility services
Hospital non-emergency or outpatient clinic services on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment.
Ophthalmology and Optometry services
Obstetric (antepartum, delivery, ~~deliver~~ and postpartum) services
Pharmacy
Physician Services for inpatients acute care.
Transportation

State of Arkansas *As Engrossed: H3/25/19 S4/3/19*
92nd General Assembly **A Bill**
Regular Session, 2019 HOUSE BILL 1656

By: Representative D. Ferguson
By: Senator Bledsoe

For An Act To Be Entitled

AN ACT TO AMEND THE PRIOR AUTHORIZATION TRANSPARENCY ACT; TO PROHIBIT PRIOR AUTHORIZATION FOR MEDICATION-ASSISTED TREATMENT; TO DECLARE AN EMERGENCY; AND FOR OTHER PURPOSES.

Subtitle

TO AMEND THE PRIOR AUTHORIZATION TRANSPARENCY ACT; TO PROHIBIT PRIOR AUTHORIZATION FOR MEDICATION-ASSISTED TREATMENT; AND TO DECLARE AN EMERGENCY.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code § 23-99-1103(8), concerning the definition of "healthcare insurer" under the Prior Authorization Transparency Act, is amended to read as follows:

(8)(A)(i) "Healthcare insurer" means an entity that is subject to state insurance regulation, including an insurance company, a health maintenance organization, ~~self-insured health plan for employees of a governmental entity, and~~ a hospital and medical service corporation, a risk-based provider organization, and a sponsor of a nonfederal self-funded governmental plan.

(ii) "Healthcare insurer" includes Medicaid where specifically referenced in § 23-99-1119.

(B) "Healthcare insurer" does not include:

(i) ~~workers' compensation plans or~~ A workers'

compensation plan; ~~or~~

(ii) Medicaid~~.~~, except as provided under § 23-99-1119 or when Medicaid services are managed or reimbursed by a healthcare insurer; or

~~(C) "Healthcare insurer" does not include an~~ (iii) An entity that provides only dental benefits or eye and vision care benefits;

SECTION 2. Arkansas Code § 23-99-1103, concerning the definitions under the Prior Authorization Transparency Act, is amended to add an additional subdivision to read as follows:

(21) "Prescription for medication-assisted treatment" means any prescription for medication used as treatment for opioid addiction approved by the United States Food and Drug Administration.

SECTION 3. Arkansas Code Title 23, Chapter 99, Subchapter 11, is amended to add an additional section to read as follows:

23-99-1119. Medication-assisted treatment for opioid addiction.

(a) Except in the case of injectables, a healthcare insurer, including Medicaid, shall not:

(1) Require prior authorization in order for a patient to obtain coverage of buprenorphine, naloxone, naltrexone, methadone, and their various formulations and combinations approved by the United States Food and Drug Administration for the treatment of opioid addiction; or

(2) Impose any other requirement other than a valid prescription and compliance with the medication-assisted treatment guidelines issued by the Substance Abuse and Mental Health Services Administration under the United States Department of Health and Human Services in order for a patient to obtain coverage for buprenorphine, naloxone, naltrexone, methadone, and their various formulations and combinations approved by the United States Food and Drug Administration for the treatment of opioid addiction.

(b) Subdivision (a)(1) of this section shall only apply to the Arkansas Medicaid Program as it pertains to prescription drugs for treatment of opioid addiction designated as preferred on the evidence-based preferred drug list provided there is at least one (1) of each of the drugs listed in subdivision (a)(1) of this section with the preferred designation on the preferred drug list or available without prior authorization.

(c) If a new formulation or medication approved by the United States Food and Drug Administration for use as a prescription for medication-assisted treatment becomes available after the effective date of this section and is either more expensive or has not been shown to be more effective than the formulations and medications in subsection (a) of this section, then the healthcare insurer may require prior authorization of the new formulation or medication.

(d) A healthcare insurer utilizing a tiered drug formulary shall place on the lowest-cost benefit tier at least one (1) product for each of the following medications that is approved by the United States Food and Drug Administration:

(1) Buprenorphine;

(2) Naloxone;

(3) Naltrexone;

(4) Methadone; and

(5) A product containing both buprenorphine and naloxone.

(e) For purposes of any limit a healthcare insurer imposes on the number of prescriptions for a patient, a prescription for medication-assisted treatment shall not be counted.

(f) This section does not affect the responsibility of a healthcare provider to comply with the standard of care for medication-assisted treatment, including without limitation the use of therapy in combination with medication.

(g) The Arkansas Medicaid Program shall have until January 1, 2020, to comply with this section.

SECTION 4. EMERGENCY CLAUSE. It is found and determined by the General Assembly of the State of Arkansas that medication-assisted treatment is effective at treating opioid addiction and results in substantial cost savings; that some healthcare insurers, including Medicaid, are placing numerous prior authorization requirements on healthcare providers and their patients who are in need of medication-assisted treatment; that these requirements are counterproductive; and that this act is immediately necessary because, as a result of these requirements, patients resort to continued illegal drug use to stop withdrawals and physicians may be deterred from treating patients due to the difficult prior authorization requirements.

Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on:

(1) The date of its approval by the Governor;

(2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or

(3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.

/s/D. Ferguson

APPROVED: 4/12/19