EXHIBIT E

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL AND JOINT INTERIM COMMITTEE

DEPARTMENT/AGENCY Department of Human Services

DIVISION Division of Medical Services

DIVISION DIRECTOR Dr. Andrew Allison

CONTACT PERSON Evelyn Block/Rosemary Edgin

ADDRESS P.O. Box 1437, Slot S295, Little Rock, AR 72203

PHONE NO. 501-320-6430 **FAX NO.** 501-682-2480 **E-MAIL** Evelyn.Block@Arkansas.gov

NAME OF PRESENTER AT COMMITTEE MEETING Marilyn Strickland

PRESENTER E-MAIL marilyn.strickland@arkansas.gov

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.
D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:

Donna K. Davis
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
One Capitol Mall, 5th Floor
Little Rock, AR 72201

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1. What is the short title of this rule? State Plan Amendment # 2013-024 and Prosthetics 5-13

2. What is the subject of the proposed rule? DME MIC-KEY Percutaneous Cecostomy Tube and the MIC-KEY Skin Level Gastrostomy Tube is expanded to cover beneficiaries of all ages.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ☐ No ☒
   If yes, please provide the federal rule, regulation, and/or statute citation. _____

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes ☐ No ☒
   If yes, what is the effective date of the emergency rule? _____

   When does the emergency rule expire? _____

Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act? Yes ☐ No ☐

5. Is this a new rule? Yes ☐ No ☒
If yes, please provide a brief summary explaining the regulation. _____

Does this repeal an existing rule? Yes ☐ No ☒
If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does. _____

Is this an amendment to an existing rule? Yes ☒ No ☐
If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled "mark-up."**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. Arkansas Statute 20-76-201

7. What is the purpose of this proposed rule? Why is it necessary? This rule authorizes Arkansas Medicaid to reimburse providers for use of the MIC-KEY Percutaneous Cecostomy Tube (Mic-Key Button) for all ages and expands the MIC-KEY Skin Level Gastrostomy Tube coverage to all ages. This rule is necessary to ensure that Medicaid beneficiaries are provided with adequate medical supplies to treat their health needs.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).
https://www.medicaid.state.ar.us/InternetSolution/general/comment/comment.aspx

9. Will a public hearing be held on this proposed rule? Yes ☐ No ☒
If yes, please complete the following:
Date: _____
Time: _____
Place: _____

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)
December 10, 2013

11. What is the proposed effective date of this proposed rule? (Must provide a date.)
March 1, 2014

12. Do you expect this rule to be controversial? Yes ☐ No ☒
If yes, please explain. _____

13. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services
DIVISION Division of Medical Services
PERSON COMPLETING THIS STATEMENT Brian Jones
TELEPHONE NO. 501-537-2064 **FAX NO.** 501-682-3889 **EMAIL:** brian.jones@Arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE State Plan Amendment #2013-024 and Prosthetics 5-13

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☒ No ☐

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   _____

   (b) The reason for adoption of the more costly rule;

   _____

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   _____

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

   _____

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	

Total _____ Total _____

(b) What is the additional cost of the state rule?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$ 3,000	General Revenue	$ 9,000
Federal Funds	$ 7,000	Federal Funds	$ 22,000
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$ 10,000	Total	$ 31,000

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year	**Next Fiscal Year**
$ 0	$ 0

Additional coverage of the MIC-KEY Button will be provide needed medical care to the beneficiaries

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year	**Next Fiscal Year**
$ 3,000	$ 9,000

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☒

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

Summary for
State Plan Amendment #2013-024 and
Prosthetics 5-13

Effective for claims with dates of service March 1, 2014 and after, the Arkansas Department of Human Services is implementing coverage of the MIC-KEY Percutaneous Cecostomy Tube for all ages. In addition, the MIC-KEY Skin Level Gastrostomy Tube will be expanded to coverage for all ages. Arkansas Medicaid has estimated an annual budget impact of $31,000.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-682-2480

TO: Arkansas Medicaid Health Care Providers – Prosthetics

DATE: March 1, 2014

SUBJECT: Provider Manual Update Transmittal PROSTHET-5-13

PROPOSED

REMOVE		INSERT	
Section	**Date**	**Section**	**Date**
212.209	4-1-09	212.209	3-1-14
212.210	8-1-05	212.210	3-1-14
242.153	7-1-07	242.153	3-1-14

Explanation of Updates

Section 212.209 is updated to indicate that Arkansas Medicaid reimburses for the MIC-KEY Skin Level Gastrostomy Tube (MIC-KEY button) and supplies for beneficiaries of all ages.

Section 212.210 is updated from Reserved to describe the reimbursement policy for a MIC-KEY Percutaneous Cecostomy Tube.

Section 242.153 is updated to indicate that Arkansas Medicaid reimburses for the MIC-KEY Skin Level Gastrostomy Tube (MIC-KEY button) and MIC-KEY Percutaneous Cecostomy Tube and supplies for beneficiaries of all ages.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at 501-320-6429.

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

Thank you for your participation in the Arkansas Medicaid Program.

Andy Allison

Andrew Allison, PhD
Director

TOC required

PROPOSED

212.209 (DME) MIC-KEY Skin Level Gastrostomy Tube (MIC-KEY Button) and Supplies for Beneficiaries of All Ages 3-1-14

The Arkansas Medicaid Program reimburses for the MIC-KEY Skin Level Gastrostomy Tube (MIC-KEY button) and supplies for Medicaid-eligible beneficiaries of all ages. Prior authorization (PA) from AFMC is required.

When requesting prior authorization, form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components*, must be completed and sent, along with sufficient medical documentation, to AFMC.

The MIC-KEY Kit is benefit-limited to 2 per state fiscal year (SFY). The accessories, extension sets and adapters are covered under the $250 medical supply benefit limit.

Benefit extensions will be considered on a case-by-case basis if proven to be medically necessary. Prior authorization must be obtained from AFMC for any extensions using form DMS-679A. **View or print AFMC contact information. View or print form DMS-679A and instructions for completion.**

212.210 DME MIC-KEY Percutaneous Cecostomy Tube (MIC-KEY button) for Beneficiaries of All Ages 3-1-14

The Arkansas Medicaid Program reimburses for the MIC-KEY Percutaneous Cecostomy Tube (MIC-KEY button) for Medicaid-eligible beneficiaries of all ages. Arkansas Medicaid will reimburse the MIC-KEY Skin Level Gastrostomy Tube for all ages, when used for the management of severe fecal incontinence (see diagnosis codes below) requiring percutaneous cecostomy tube placement for bowel evacuation. Prior authorization (PA) from AFMC is required.

When requesting prior authorization, form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs and Wheelchair Components*, must be completed and sent, along with sufficient medical documentation, to AFMC. **View or print AFMC contact information. View or print form DMS-679A and instructions for completion.**

The MIC-KEY button is benefit-limited to 2 per state fiscal year (SFY).

The MIC-KEY button for a Percutaneous Cecostomy Tube requires use of the following diagnosis codes:

Diagnosis Code	Description
564.00-564.09	Constipation
787.60	Fecal Incontinence
787.61	Incomplete Defecation
787.62	Fecal Soiling

The MIC-KEY button for a Percutaneous Cecostomy Tube requires use of the following CPT codes:

44300	49442	49450

242.153 **MIC-KEY Skin Level Gastrostomy Tube (MIC-KEY Button) and MIC-KEY Percutaneous Cecostomy Tube and Supplies for Beneficiaries of All Ages** 3-1-14

NOTE: When billing for the MIC-KEY Percutaneous Cecostomy Tube and/or supplies, an additional third modifier UA will be required.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.

Procedure Code	M1	M2	PA	Description	Payment Method
B9998			Y	MIC-KEY Kit	Purchase
B9998	NU	U1	Y	SECUR-LOK Extension Set with 2 Port 'Y' and Clamp 12" Length	Purchase
B9998	NU	U2	Y	SECUR-LOK Extension Set with 2 Port 'Y' and Clamp 24" Length	Purchase
B9998	NU	U3	Y	Bolus Extension Set with Single Port Clamp 12" Length	Purchase
B9998	NU	U4	Y	Bolus Extension Set with Single Port Clamp 24" Length	Purchase
B9998	NU	U5	Y	Bolus SECUR-LOK Extension Set Single Port w/Clamp 12" Length	Purchase
B9998	NU	U6	Y	Bolus SECUR-LOK Extension Set Single Port w/Clamp 24" Length	Purchase
B9998	NU	U7	Y	Microvasive Adapter	Purchase
B9998	NU	U8	Y	Microvasive Decompression Tube	Purchase

TOC required

212.209 (DME) MIC-KEY Skin Level Gastrostomy Tube (MIC-KEY Button) and Supplies for Beneficiaries of All Ages 3-1-14

The Arkansas Medicaid Program reimburses for the MIC-KEY Skin Level Gastrostomy Tube (MIC-KEY button) and supplies for Medicaid-eligible beneficiaries of all ages. Prior authorization (PA) from AFMC is required.

When requesting prior authorization, form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components*, must be completed and sent, along with sufficient medical documentation, to AFMC.

The MIC-KEY Kit is benefit-limited to 2 per state fiscal year (SFY). The accessories, extension sets and adapters are covered under the $250 medical supply benefit limit.

Benefit extensions will be considered on a case-by-case basis if proven to be medically necessary. Prior authorization must be obtained from AFMC for any extensions using form DMS-679A. **View or print AFMC contact information. View or print form DMS-679A and instructions for completion.**

212.210 DME MIC-KEY Percutaneous Cecostomy Tube (MIC-KEY button) for Beneficiaries of All Ages 3-1-14

The Arkansas Medicaid Program reimburses for the MIC-KEY Percutaneous Cecostomy Tube (MIC-KEY button) for Medicaid-eligible beneficiaries of all ages. Arkansas Medicaid will reimburse the MIC-KEY Skin Level Gastrostomy Tube for all ages, when used for the management of severe fecal incontinence (see diagnosis codes below) requiring percutaneous cecostomy tube placement for bowel evacuation. Prior authorization (PA) from AFMC is required.

When requesting prior authorization, form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs and Wheelchair Components*, must be completed and sent, along with sufficient medical documentation, to AFMC. **View or print AFMC contact information. View or print form DMS-679A and instructions for completion.**

The MIC-KEY button is benefit-limited to 2 per state fiscal year (SFY).

The MIC-KEY button for a Percutaneous Cecostomy Tube requires use of the following diagnosis codes:

Diagnosis Code	Description
564.00-564.09	Constipation
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787.62	Fecal Soiling

The MIC-KEY button for a Percutaneous Cecostomy Tube requires use of the following CPT codes:

44300	49442	49450

242.153 **MIC-KEY Skin Level Gastrostomy Tube (MIC-KEY Button) and MIC-KEY Percutaneous Cecostomy Tube and Supplies for Beneficiaries of All Ages** 3-1-14

NOTE: When billing for the MIC-KEY Percutaneous Cecostomy Tube and/or supplies, an additional third modifier UA will be required.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.

Procedure Code	M1	M2	PA	Description	Payment Method
B9998			Y	MIC-KEY Kit	Purchase
B9998	NU	U1	Y	SECUR-LOK Extension Set with 2 Port 'Y' and Clamp 12" Length	Purchase
B9998	NU	U2	Y	SECUR-LOK Extension Set with 2 Port 'Y' and Clamp 24" Length	Purchase
B9998	NU	U3	Y	Bolus Extension Set with Single Port Clamp 12" Length	Purchase
B9998	NU	U4	Y	Bolus Extension Set with Single Port Clamp 24" Length	Purchase
B9998	NU	U5	Y	Bolus SECUR-LOK Extension Set Single Port w/Clamp 12" Length	Purchase
B9998	NU	U6	Y	Bolus SECUR-LOK Extension Set Single Port w/Clamp 24" Length	Purchase
B9998	NU	U7	Y	Microvasive Adapter	Purchase
B9998	NU	U8	Y	Microvasive Decompression Tube	Purchase

CATEGORICALLY NEEDY

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

21. Other Licensed Practitioners (Continued)

3. Licensed Marriage and Family Therapist (LMFT)

a. Services are limited to Medicaid eligible recipients under age 21 in the Child Health Services (EPSDT) Program.

b. Services must be provided by a licensed marriage and family therapist (LMFT) who must possess a Master's degree in mental health counseling from an accredited college or university. The LMFT must be licensed as a Licensed Marriage and Family Therapist and in good standing with the Arkansas Board of Examiners in Counseling.

c. A referral must be made by a Medicaid enrolled physician documenting services are medically necessary. Covered outpatient LMFT services are:

1. Diagnosis
2. Interpretation of Diagnosis
3. Crisis Management Visit
4. Individual Outpatient - Therapy Session*
5. Marital/Family Therapy*
6. Individual Outpatient - Collateral Services*
7. Group Outpatient - Group Therapy*

* Effective April 1, 2002, these services require prior authorization for eligible Medicaid recipients under age 21 to determine and verify the patient's need for services.

MEDICALLY NEEDY

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

21. Other Licensed Practitioners (Continued)

PROPOSED

3. Licensed Marriage and Family Therapist (LMFT)

a. Services are limited to Medicaid eligible recipients under age 21 in the Child Health Services (EPSDT) Program.

b. Services must be provided by a licensed marriage and family therapist (LMFT) who must possess a Master's degree in mental health counseling from an accredited college or university. The LMFT must be licensed as a Licensed Marriage and Family Therapist and in good standing with the Arkansas Board of Examiners in Counseling.

c. A referral must be made by a Medicaid enrolled physician documenting services are medically necessary. Covered outpatient LMFT services are:

1. Diagnosis
2. Interpretation of Diagnosis
3. Crisis Management Visit
4. Individual Outpatient - Therapy Session*
5. Marital/Family Therapy*
6. Individual Outpatient - Collateral Services*
7. Group Outpatient - Group Therapy*

* Effective April 1, 2002, these services require prior authorization for eligible Medicaid recipients under age 21 to determine and verify the patient's need for services.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Revised: March 1, 2014

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(24) Other Licensed Practitioners

PROPOSED

1. Licensed Certified Social Worker (LCSW)

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) Maximum charge allowed. The Title XIX Maximum is 80% of the psychologist fee schedule.

2. Licensed Professional Counselor (LPC)

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) Maximum charge allowed. The Title XIX Maximum is 80% of the psychologist fee schedule.

3. Licensed Marriage and Family Therapist (LMFT)

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) Maximum charge allowed. The Title XIX Maximum is 80% of the psychologist fee schedule.

PROPOSED

7. Home Health Services (Continued)

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home (continued)

(12) **MIC-KEY Skin Level Gastrostomy Tube and Percutaneous Cecostomy Tube and Supplies**

Effective for dates of service on or after September 1, 2000, reimbursement is based on the lesser of the provider's actual charge for the MIC-KEY kits and accessories or the Title XIX (Medicaid) maximum. The agency's rates were set as of September 1, 2000, and are effective for services on or after that date. All rates are published on the agency's website (www.medicaid.state.ar.us). Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of DME services. There is only one manufacturer of the MIC-KEY kits and accessories. The Title XIX (Medicaid) maximum for the kit and accessories is based on the manufacturer's list prices to the DME providers as of July 1, 2000 plus 10%. The State Agency will review the manufacturer's list prices annually and may adjust the Medicaid maximums if necessary. Arkansas Medicaid will reimburse providers for the kit and accessories as purchase only items.

Effective for dates of service on or after March 1, 2014, coverage of the MIC-KEY for Percutaneous Cecostomy Tube will be reimbursed based on the above-mentioned methodology.

7. Home Health Services (Continued)

PROPOSED

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home (continued)

(12) **MIC-KEY Skin Level Gastrostomy Tube and Percutaneous Cecostomy Tube and Supplies**

Effective for dates of service on or after September 1, 2000, reimbursement is based on the lesser of the provider's actual charge for the MIC-KEY kits and accessories or the Title XIX (Medicaid) maximum. The agency's rates were set as of September 1, 2000, and are effective for services on or after that date. All rates are published on the agency's website (www.medicaid.state.ar.us). Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of DME services. There is only one manufacturer of the MIC-KEY kits and accessories. The Title XIX (Medicaid) maximum for the kit and accessories is based on the manufacturer's list prices to the DME providers as of July 1, 2000 plus 10%. The State Agency will review the manufacturer's list prices annually and may adjust the Medicaid maximums if necessary. Arkansas Medicaid will reimburse providers for the kit and accessories as purchase only items.

Effective for dates of service on or after March 1, 2014, coverage of the MIC-KEY for Percutaneous Cecostomy Tube will be reimbursed based on the above-mentioned methodology.

d. Physical Therapy

Refer to Item 4.b.(19).

Mark Up

CATEGORICALLY NEEDY

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

21. Other Licensed Practitioners (Continued)

3. Licensed Marriage and Family Therapist (LMFT)

a. Services are limited to Medicaid eligible recipients under age 21 in the Child Health Services (EPSDT) Program.

b. Services must be provided by a licensed marriage and family therapist (LMFT) who must possess a Master's degree in mental health counseling from an accredited college or university. The LMFT must be licensed as a Licensed Marriage and Family Therapist and in good standing with the Arkansas Board of Examiners in Counseling.

c. A referral must be made by a Medicaid enrolled physician documenting services are medically necessary. Covered outpatient LMFT services are:

1. Diagnosis
2. Interpretation of Diagnosis
3. Crisis Management Visit
4. Individual Outpatient - Therapy Session*
5. Marital/Family Therapy*
6. Individual Outpatient - Collateral Services*
7. Group Outpatient - Group Therapy*

22. Medical Supplies

~~1. MIC-KEY Skin Level Gastrostomy Tube and Supplies~~

~~Effective for dates of service on or after September 1, 2000 MIC-KEY Skin Level Gastrostomy Tube and Supplies are covered for Medicaid eligible recipients under age 21. Services require prior authorization. The MIC-KEY kit is limited to two (2) per State Fiscal Year. Benefit extensions will be considered on a case-by-case basis based on medical necessity.~~

* **Effective April 1, 2002, these services require prior authorization for eligible Medicaid recipients under age 21 to determine and verify the patient's need for services.**

MEDICALLY NEEDY

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

21. Other Licensed Practitioners (Continued)

3. Licensed Marriage and Family Therapist (LMFT)

a. Services are limited to Medicaid eligible recipients under age 21 in the Child Health Services (EPSDT) Program.

b. Services must be provided by a licensed marriage and family therapist (LMFT) who must possess a Master's degree in mental health counseling from an accredited college or university. The LMFT must be licensed as a Licensed Marriage and Family Therapist and in good standing with the Arkansas Board of Examiners in Counseling.

c. A referral must be made by a Medicaid enrolled physician documenting services are medically necessary. Covered outpatient LMFT services are:

1. Diagnosis
2. Interpretation of Diagnosis
3. Crisis Management Visit
4. Individual Outpatient - Therapy Session*
5. Marital/Family Therapy*
6. Individual Outpatient - Collateral Services*
7. Group Outpatient - Group Therapy*

22. Medical Supplies

~~1. MIC-KEY Skin-Level Gastrostomy Tube and Supplies~~

~~Effective for dates of service on or after September 1, 2000 MIC-KEY Skin-Level Gastrostomy Tube and Supplies are covered for Medicaid eligible recipients under age 21. Services require prior authorization. The MIC-KEY kit is limited to two (2) per State Fiscal Year. Benefit extensions will be considered on a case by case basis based on medical necessity.~~

* **Effective April 1, 2002, these services require prior authorization for eligible Medicaid recipients under age 21 to determine and verify the patient's need for services.**

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(24) Other Licensed Practitioners

1. Licensed Certified Social Worker (LCSW)

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) Maximum charge allowed. The Title XIX Maximum is 80% of the psychologist fee schedule.

2. Licensed Professional Counselor (LPC)

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) Maximum charge allowed. The Title XIX Maximum is 80% of the psychologist fee schedule.

3. Licensed Marriage and Family Therapist (LMFT)

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) Maximum charge allowed. The Title XIX Maximum is 80% of the psychologist fee schedule.

(25) Medical Supplies

~~1. MIC-KEY Skin Level Gastrostomy Tube and Supplies~~

~~Effective for dates of service on or after September 1, 2000, reimbursement is based on the lesser of the provider's actual charge for the MIC-KEY kits and accessories or the Title XIX (Medicaid) maximum. There is only one manufacturer of the MIC-KEY kits and accessories. The Title XIX (Medicaid) maximum for the kit and accessories is based on the manufacturer's list prices to the DME providers as of July 1, 2000 plus 10%. The State Agency will review the manufacturer's list prices annually and may adjust the Medicaid maximums if necessary. Arkansas Medicaid will reimburse providers for the kit and accessories as purchase only items.~~