TOC required

214.210 ~~General~~ Advanced Practice Registered Nurse (APRN) ~~Practitioner~~ Services Benefit Limits

~~7-1-15-16~~1-~~2022~~

A. ~~For beneficiaries aged~~clients ~~twenty-one~~ 21 ~~years of age~~ and older, services provided ~~in~~ by ~~an~~ Advanced Practice Registered ~~N~~ nurse ~~(APRN) in the APRN's practitioner's office, a patient's client's home or nursing home are limited to 12~~ sixteen (16) visits per ~~S~~state ~~F~~fiscal ~~Y~~year ~~(SFY/July 1 through June 30) when the APRN is enrolled in the Medicaid Primary Care Physician (PCP) program.~~For clients twenty-one (21) years of age or older, APRN services provided in a physician office, an APRN office, a patient's home, or nursing home are limited to twelve (12) visits per state fiscal year (SFY) (July 1 through June 30) unless the client is assigned to a provider enrolled in the Primary Care Case Management Program (PCCM). If the client is assigned to a provider enrolled in the PCCM, the limit is sixteen (16) visits.

The following services are counted toward the ~~12 sixteen (16) visits per S~~state ~~F~~fiscal ~~Y~~year ~~(SFY/July 1 to June 30) limit established for the Nurse Practitioner Primary Care Physician P~~program Service Benefit ~~Visit~~ Limits established for the state fiscal year:

~~1. Services of Primary Care Physicians in the office, client's home, or nursing facility.~~

~~2. Services of Advanced Practice Registered Nurses (APRNs) who are enrolled in the PCP program in the office, home, or nursing facility.~~

A. APRN~~Advanced nurse practitioner~~ services in the office, patient's home, or nursing facility~~.~~

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

C. Rural health clinic (RHC) encounters~~.~~

D. Medical services ~~provided~~ furnished by a dentist~~.~~

E. Medical services furnished by an optometrist~~.~~

F. Certified nurse-midwife services~~.~~

G. Federally ~~Q~~qualified ~~H~~health ~~C~~center (FQHC) encounters

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

Global obstetric fees are not counted against the ~~sixteen (16)12~~ visit limit. ~~-~~Itemized obstetric office visits are not counted in the limit.

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

~~B. For clients twenty-one (21) years of age and older, services provided by an Advanced Practice Registered Nurse (APRN) not enrolled in the Medicaid Primary Care Physician (PCP) program in their office, a client's home, or nursing home are limited to twelve (12) visits per State Fiscal Year (SFY/July 1 through June 30).~~

~~1. The following services are counted toward the twelve (12) visits per SFY limit established for the Advanced Practice Registered Nurse (APRN) not enrolled in the PCP program when furnished in the office, client's home, or nursing facility.~~

~~2. Specialty physician services in the office, client's home, or nursing facility.~~

~~3. Rural health clinic (RHC) encounters.~~

4. Medical services provided by a dentist.

5. Medical services furnished by an optometrist.

6. Any combination of the five (5) service provider types.

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

Global obstetric fees are not counted against the twelve (12) visit limit. Itemized obstetric office visits are not counted in the limit.

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

225.000 Outpatient Hospital Benefit Limit

~~7~~1~~9~~-1-~~20~~2~~20~~

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

A. Outpatient hospital services include the following:

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

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

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

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

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

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

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

226.000 Physician Services Benefit Limit

~~7~~1~~9~~-1-~~20~~2~~20~~

~~1.~~ **Primary Care ~~Physician~~Provider Program**

A. ~~Primary Care Physician (PCP) services in a physician's office, patient's client's home, or nursing home for beneficiaries clients aged twenty-one (21) years of age or older are limited to twelve sixteen (162) visits per Sstate Ffiscal Yyear (SFY/July 1 through June 30). Beneficiaries Clients under age twenty-one (21) years of age in the Child Health Services/Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) Program are not subject to this benefit limit.~~For clients twenty-one (21) years of age or older, services provided in a physician's office, advanced practice registered nurse's (APRN) office, a patient's home, or nursing home are limited to twelve (12) visits per state fiscal year (July 1 through June 30) unless the client is assigned to a provider enrolled in the Primary Care Case Management Program (PCCM). If the client is assigned to a provider who is enrolled in the PCCM the limit is sixteen (16) visits.

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

The following services are counted toward the ~~sixteen~~twelve ~~(16~~2) ~~visits per state fiscal year limit established for the Primary Care Physician Program~~service benefit limits:

1. Services of ~~Primary Care P~~physicians ~~services~~ in the office, ~~patient's~~ client's home, or nursing facility.
2. ~~Rural health clinic (RHC) encounters~~~~Services of Advanced Practice Registered Nurses (APRN) who are enrolled in the PCP Program in the office, client's home, or nursing facility.~~Medical services provided by a dentist.
3. Medical services furnished by an optometrist.
4. Certified nurse-midwife services.
5. ~~Advanced nurse practitioner~~APRN services in the office, client's home, or nursing facility.
6. Rural health clinic (RHC) encounters.
7. Federally qualified health center (FQHC) 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 the~~is~~ manual for procedures on obtaining extension of benefits for Primary Care ~~P~~physician~~P~~rovider (PCP) services.

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

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

When a Medicaid ~~beneficiary's~~ client's primary diagnosis is one (1) of those listed above and the ~~beneficiary~~ client has exhausted the Medicaid established benefit for physician, APRN, and physician assistant services, ~~specialty 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.

~~2. **Specialty Physician Services**~~

~~A. Specialty Physician services in a physician's office, patient's client's home, or nursing home for beneficiaries clients aged twenty-one (21) years of age or older are limited to twelve (12) visits per Sstate Ffiscal Yyear (SFY/July 1 through June 30). Beneficiaries Clients under age twenty-one (21) years of age in the Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program are not subject to this benefit limit.~~

~~The following services are counted toward the twelve (12) visits per Sstate Ffiscal Yyear limit established for the Physician Specialty Physician Program:~~

1. Specialty Physician services in the office, patient's client's home, or nursing facility.
2. Rural health clinic (RHC) encounters.
3. Medical services provided by a dentist.
4. Medical services furnished provided by an optometrist.
5. Certified nurse-midwife services.
56. Services of an Advanced Practice Registered Nnurse (APRN) practitioner servicesnot enrolled in the PCP program.

B. Extensions of this benefit are considered when documentation verifies medical necessity. Refer to Sections 229.100 through 229.120 of this the manual for procedures on obtaining extension of benefits for Specialty Pphysician services.

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

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

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

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

257.000 Tobacco Cessation Products and Counseling Services

8-1-2171-1-202022

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

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

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

C. Counseling procedures do not count against the twelve (12) visit limits alloweds per Sstate Ffiscal Yyear (SFY/July 1 to June 30), but they are limited to no more than two (2) 15 (fifteen) minute units and two (2) thirty (30) minute units for a maximum allowable of four (4) units per SFY.

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

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

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

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

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

~~10-13-03~~71-1-2022

292.740 Psychotherapy

The psychotherapy procedures covered under the Physician Program are allowed as a covered service when provided by the physician or when provided by a qualified practitioner who by State licensure is authorized to provide psychotherapy services. ~~When a practitioner other than the physician provides the services, the services must be under the direct supervision of the physician billing for the service. For the purposes of psychotherapy services only, the term "direct supervision" means the following:~~

~~A. The person who is performing the service must be: (1) a paid employee of the physician (the physician who is billing the Medicaid Program). A W-4 Form must be on file in the physician's office or (2) a subcontractor of the physician (the physician who is billing the Medicaid Program). A contract between the physician and the subcontractor must be on file in the physician's office and~~

~~B. The physician must monitor and be responsible for the quality of work performed by the employee or subcontractor under his "direct supervision." The physician must be immediately available to provide assistance~~assist ~~and direction~~ direct ~~throughout the time the service is being performed.~~

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

TOC ~~not~~ required

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

~~9-15-09~~71-1-22

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

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

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

~~All other PCP-qualified physicians and clinics must enroll as PCPs, except for physicians who certify in writing that they are employed exclusively by an Area Health Education Center (AHEC),a University of Arkansas Medical School (UAMS) Regional Program, a Federally Qualified Health Center (FQHC), a Medical College Physicians Group, or a hospital (i.e., they are "hospitalists" and they practice exclusively in a hospital).~~

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

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

E. Advanced p~~P~~ractice r~~R~~egistered n~~N~~urses (APRN) licensed by the Arkansas State Board of Nursing may choose to enroll as PCPs.

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

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

171.630 ~~Nurse Practitioners~~Advanced Practice Registered Nurses and Physician Assistants in Rural Health Clinics (RHCs)

~~7-1-05~~71-1-22

Advanced p~~P~~ractice r~~R~~egistered n~~N~~urses (APRN) may function as Primary Care Providers at the performing provider level.

Licensed registered nurse practitioners (RNP) or licensed p~~P~~physician A~~a~~ssistants (PA) employed by a Medicaid-enrolled rural health clinic (RHC) ~~(Rural Health Clinic)~~ provider may not function as Primary Care ~~Physician~~Provider (PCP) substitutes, but they may provide primary care for a PCP's enrollees, with certain restrictions.

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

1. To the PCP's client enrollees
2. By registered nurse practitioners and physician assistants

3. In ~~and/~~or on behalf of the RHC

B. Registered nurse practitioners and p~~P~~physician a~~A~~assistants (PA) may not make referrals for medical services except for pharmacy services per established protocol.

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

218.100 RHC Encounter Benefit Limits 79-1-220

A. There is no RHC encounter benefit limit for Medicaid beneficiaries clients under the age of twenty-one (21) in the Child Health Services (EPSDT) Program do not have a rural health clinic (RHC) encounter benefit limit.

B. A benefit limit of twelve sixteen (162) visits encounters per state fiscal year (SFY), July 1 through June 30, has been established for beneficiaries clients aged twenty-one (21) and years or older who are assign4ed to a provider enrolled in the Primary Care Case Management (PCCM) program. If the client is not assigned to a provider enrolled in the PCCM, the service limit will be set at twelve (12). The following services are counted toward the twelve (12) visits per SFY encounter 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 practitionerpractice registered nurse services in the office, patient's home, or nursing facility; and.
7. Federally Qqualified Hhealth Ccenter (FQHC) encounters.

Global obstetric fees are not counted against the 12-visit service encounter limit. Itemized obstetric office visits are not counted in the limit.

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

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

218.300 Extension of Benefits 710-1-1522

RHC encounters count toward the 12 visits per SFY benefit limitservice benefit limits per state fiscal year. Arkansas Medicaid considers, upon written request, extending the RHC benefit for reasons of medical necessity.

A. Extensions of family planning benefits are not available.

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

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

2.b. Rural Health Clinic Services

Rural health clinic services are limited to ~~twelve (12)~~sixteen (16) ~~visits~~ encounters a year for ~~beneficiaries age~~clients twenty-one (21) years of age and older, when the client is assigned to a provider enrolled in the Primary Care Case Management (PCCM) program. This yearly limit is based on the State Fiscal Year (July I through June 30). If the client is not assigned to a provider enrolled in the PCCM program the service limit will be set at twelve (12). The benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, ~~and~~ certified nurse midwife services, federally qualified health center encounters, and advanced practice registered nurse services ~~when they are enrolled in the primary care case management program (PCCM)~~, or a combination of the seven.

~~Beneficiaries will be allowed twelve (12) visits per State Fiscal Year for rural health clinic services, physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services or a combination of the five. For physicians' services, medical services provided by a dentist, office medical services furnished by an optometrist certified nurse midwife services or rural health clinic core services beyond the 12 visit limit, e~~Extensions of the benefit limit will be ~~provided~~ available if medically necessary. **Certain services, specified in the appropriate provider manual, are not counted toward the ~~12~~ ~~visit~~ limit.** ~~Beneficiaries~~ Clients under age twenty-one (2l) in the Child Health Services (EPSDT) Program are not benefit limited.

Rural ~~Health~~ health ~~Clinic~~ clinic core services are defined as follows:

1. Physicians' services, advanced practice registered nurse's services, ~~including required physician supervisory services of nurse practitioners~~ and physician assistant services when properly ~~supervised~~s;

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

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

3. Clinical psychologist services;

4. Clinical social worker services;

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

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

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

2.c. Federally ~~Qualified~~ qualified ~~Health~~ health ~~Center~~ 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~~ Federally qualified health center ~~(FQHC)~~ services are limited to ~~twelve (12)~~sixteen (16) encounters per ~~beneficiary~~client, per State Fiscal Year (July 1 through June 30) for ~~beneficiaries~~ clients ~~age~~ **twenty-one** (21) ~~and~~ years or older when the client is ~~assigned older~~to a provider within the PCCM program. If the client is not assigned to a provider enrolled in the PCCM program, the service limit will ~~set~~ be set at twelve (12). The applicable benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, rural health clinic encounters, and advanced practice registered nurse services, or a combination of the seven.

For federally qualified health center core services beyond the ~~12~~ benefit ~~visit~~ limit, extensions will be ~~provided~~ available if medically necessary. Beneficiaries under age **twenty-one** (21) in the Child Health Services (EPSDT) Program are not benefit limited.

FQHC hospital visits are limited to one (1) day of care for inpatient hospital covered days

regardless of the number of hospital visits rendered. The hospital visits do not count against the FQHC encounter benefit limit.

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

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

(1) ~~Physicians' services in a physician's office, patient's home or nursing home are limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for beneficiaries age 21 and older.~~**For clients twenty-one (21) years of age or older, services provided in a physician's office, a patient's home, ~~or~~a nursing home, or elsewhere are limited to twelve (12) visits per state fiscal year (SFY) (July 1 through June 30) unless the client is assigned to a provider enrolled in the Primary Care Case Management Program (PCCM). If the client is assigned to a physician or advanced practice registered nurse (APRN) who is enrolled in the PCCM, the limit is sixteen (16) visits.**

(a) Benefit Limit Details

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

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

The benefit limit will be considered in conjunction with the benefit limit established for ~~R~~rural ~~H~~health ~~C~~clinic ~~(RHC)~~, ~~F~~federally ~~Q~~qualified ~~H~~health ~~C~~center ~~(FQHC)~~, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services **and advanced practice registered nurse ~~or registered nurse practitioner services~~ or a combination of the seven**. ~~For services beyond the established visit limit, extensions will be available if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the limit.~~ **Clients** under age twenty-one (21) in the Child Health Services (EPSDT) Program are not benefit limited.

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

(b) Extension of Benefits

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

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

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

~~()~~ **~~(iii)~~(c) Special Exceptions**

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

(~~3~~**ivi**) ~~——~~Surgical procedures **~~that~~** ~~which~~ are generally considered to be elective require a **pP**~~p~~rior **aA**~~a~~uthorization ~~-~~ from the Utilization Review Section.

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

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

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

b. Optometrists' Services (Continued)

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

(3) Office medical services provided by an optometrist are limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for ~~beneficiaries~~ clients ~~age~~ twenty-one (21) years or older. ~~and over~~.

The benefit limit will be in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, rural health clinic services, Federally Qualified Health Center services, certified nurse midwife services, and advanced practice registered nurses, ~~or registered nurse practitioner~~ or a combination of the ~~six~~seven. For services beyond the ~~twelve (12) visit~~benefit limit, extensions will be ~~provided~~ available if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the ~~12 visit~~ limit. ~~Beneficiaries in the Child Health Services (EPSDT) Program are not benefit limited.~~

c. Chiropractors' Services

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

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

(3) Effective for dates of service on or after July 1, 1996, chiropractic services will be limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for eligible Medicaid ~~recipients~~ clients ~~age~~ twenty-one (21) years ~~and~~ or older. Services provided to ~~recipients~~ clients under age twenty-one (21) in the Child Health Services (EPSDT) Program are not benefit limited.

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

d. Advanced Practice Registered Nurses (APRN)~~Practitioners and Registered Nurse Practitioners~~

~~Office medical services provided by an advanced nurse practitioner and registered nurse practitioner are limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for beneficiaries age 21 and over.~~ For clients twenty-one (21) years of age or older, services provided in an advanced practice registered nurse's ~~practitioner's~~ office, a patient's home, or nursing home are limited to twelve (12) visits per state fiscal year (July 1 through June 30) unless the client is assigned to a provider enrolled in the Primary Care Case Management Program (PCCM) as a Medicaid Primary Care Provider. If the client is assigned to a provider enrolled in the PCCM, the limit is sixteen (16) visits.

The benefit limit will be in conjunction with the benefit limit established for physicians' services, ~~R~~rural ~~H~~health ~~C~~clinic ~~(RHC),~~ medical services furnished by a dentist, office medical services furnished by an

optometrist, ~~rural health clinic services,~~ certified nurse midwife services and federally qualified health center, ~~(FQHC) advanced practice nurse or registered nurse practitioner~~ or a combination of the seven~~six~~. For services beyond the established ~~twelve (12) visit~~ benefit limit, extensions will be ~~provided~~ available if medically necessary. ~~-~~Certain services, specified in the appropriate provider manual, are not counted toward the ~~12 visit~~ limit. ~~Beneficiaries~~ Clients in the Child Health Services (EPSDT) Program are not benefit limited.

2.b. Rural Health Clinic Services

Rural health clinic services are limited to ~~twelve (12)~~ sixteen (16) visits a year for ~~beneficiaries~~ clients ~~age~~ twenty-one (21) ~~and~~ years or older who are assigned to a provider enrolled in the Primary Care Case Management (PCCM) program. This yearly limit is based on the State Fiscal Year (July I through June 30). If the client is not assigned to a provider enrolled in the PCCM program the service limit will be set at twelve (12). ~~The benefit limit will for those who are not assigned to a PCCM provider will set at twelve (12) visits per SFY.~~ Rural ~~H~~health ~~C~~clinic ~~Visits~~encounters will be considered in conjunction with the benefit limit established for physician~~s'~~ services, medical services furnished by a dentist, office medical services furnished by an optometrist, ~~and~~ certified nurse midwife services, ~~F~~federally ~~Q~~qualified ~~H~~health ~~C~~center ~~(FQHC)~~ encounters, and advanced practice registered nurse services ~~or registered nurse practitioner services,~~ or a combination of the seven. ~~. Beneficiaries will be allowed twelve (12) visits per State Fiscal Year for rural health clinic services, physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services or a combination of the five. For physicians' services, medical services provided by a dentist, office medical services furnished by an optometrist certified nurse midwife services or rural health clinic core services beyond the 12 visit limit,~~
Benefit limit extensions will be available~~provided~~ if medically necessary. **Certain services, specified in the appropriate provider manual, are not counted toward the ~~12~~service ~~visit~~ limit.** Clients~~Beneficiaries~~ under age twenty-one (21) in the Child Health Services (EPSDT) Program are not benefit limited.

Rural ~~Health~~ health ~~Clinic~~ clinic core services are defined as follows:

1. Physicians' services, advanced practice registered nurses' services, ~~including required physician supervisory services of nurse practitioners~~ and services of physician assistants when provided under proper supervision;

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

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

3. Clinical psychologist services;

4. Clinical social worker services;

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

Rural health clinic ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the ~~Rural~~ rural ~~Health~~ health ~~Clinic~~ clinic offers such a service (e.g. dental, visual, etc.). The "other ambulatory services" that are provided by the ~~Rural~~ rural ~~Health~~ health ~~Clinic~~ 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~~ qualified ~~Health~~ health ~~Center~~ 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, f~~Federally qualified health center ~~(FQHC)~~ services are limited to ~~twelve (12)~~sixteen (16) encounters per ~~beneficiary~~client, per State Fiscal Year (July 1 through June 30) for ~~beneficiaries~~ clients ~~age~~ **twenty-one** (21) ~~and~~ years or older when the client is assigned to a provider enrolled in the Primary Care Case Management (PCCM) program. If the client is not assigned to a provider enrolled in the PCCM program the service limit will be set at twelve (12)~~12~~. The applicable benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, rural health clinic encounters, and advanced practice registered nurse ~~or registered nurse practitioner~~services, or a combination of the seven.

~~For federally qualified health center core services beyond the 12-visit limit,~~ Benefit extensions will be ~~provided~~ available if medically necessary. ~~Beneficiaries~~ Clients under age **twenty-one** (21) in the Child Health Services (EPSDT) Program are not benefit limited.

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

benefit limit.

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

4.c. Family Planning Services

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

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

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

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

(i) 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

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

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

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

5. a. Physicians' Services ~~(Continued)~~

For clients twenty-one (21) years of age or older, services provided in a physician's office, a patient's home, or nursing home are limited to 12 visits per state fiscal year (July 1 through June 30) unless the client is assigned to a provider enrolled in the Primary Care Case Management Program (PCCM) as a Medicaid Primary Care Provider. If the client is assigned to a provider enrolled in the PCCM, the limit is sixteen (16) visits.

The benefit limit will be in conjunction with the benefit limit established for advance practice registered nurse or registered nurse practitioners' services. Rural Health Clinic (RHC), medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services and federally qualified health center (FQHC), or a combination of the seven. For services beyond the established visit limit, extensions will be available if medically necessary. Beneficiaries in the Child Health Services (EPSDT) Program are not benefit limited.

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

~~(a) Benefit Limit Details~~

~~The benefit limit will be considered in conjunction with the benefit limit established for rural health clinic services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services and services provided by an advanced practice nurse or registered nurse practitioner or a combination of the six. Beneficiaries under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.~~

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

~~(b) Extensions~~

~~For services beyond the 12 visit limit, extensions will be provided if medically necessary~~.

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

~~(ii)~~ (2) ~~Additionally~~, P~~p~~hysicians' visits for pregnancy in the outpatient hospital are exempt from benefit extension requirements.

(3~~2~~) Each attending physician or ~~/~~dentist is limited to billing one day of care for inpatient hospital covered days regardless of the number of hospital visits rendered.

(4~~3~~) Surgical procedures which are generally considered to be elective require prior authorization from the Utilization Review Section.

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

~~(~~6~~5~~) Organ transplants are covered as described in Attachment 3.1-E.

(7~~6~~) Consultations**, including interactive consultations (telemedicine),** are limited to two (2) per recipient per year in a physician's office, patient's home, hospital or nursing home. This yearly limit is based on the State Fiscal Year (July 1 through June 30). This limit is in addition to the yearly limit described in Item 5.(1). Extensions of the benefit limit will be provided if medically necessary for recipients.

(8~~7~~) Abortions are covered when the life of the mother would be endangered if the fetus were carried to term or for victims of rape or incest. The circumstances must be certified in writing by the woman's attending physician. Prior authorization is required.

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

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

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

b. Optometrists' Services (Continued)

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

(3) Office medical services provided by an optometrist are limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for ~~beneficiaries~~ clients ~~age~~ twenty-one (21) years or ~~and~~ over. The benefit limit will be in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, rural health clinic services, federally qualified health center, certified nurse midwife, and services provided by an advanced practice registered nurse, ~~or registered nurse practitioner~~ or a combination of the ~~six~~seven. For services beyond the twelve (12) visit limit, extensions will be provided if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the twelve (12) visit limit. Beneficiaries in the Child Health Services (EPSDT) Program are not benefit limited.

c. Chiropractors' Services

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

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

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

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

d. Advanced Practice Registered Nurses ~~Practitioners and Registered Nurse Practitioners~~

~~Office medical services provided by an advanced nurse practitioner and registered nurse practitioner are limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for beneficiaries age 21 and over. The benefit limit will be in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, rural health clinic services, certified nurse midwife services and advanced practice nurse or registered nurse practitioner or a combination of the six. For services beyond the twelve (12) visit limit, extensions will be provided if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit. Beneficiaries in the Child Health Services (EPSDT) Program are not benefit limited.~~For client's twenty-one (21) years of age or older, services provided in an advanced practice registered nurse's ~~practitioner's~~ office, a patient's home, or nursing home are limited to ~~twelve (12)~~sixteen (16) visits per state fiscal year (July 1 through June 30) ~~unless~~if the client is assigned to a provider enrolled in the PCCM~~, the limit is sixteen (16) visits~~. If the client is not assigned to a provider enrolled in the PCCM, the limit ~~is~~will be set at twelve (12) visits per

state fiscal year.

The benefit limit will be in conjunction with the benefit limit established for physicians' services, ~~R~~rural ~~H~~health ~~C~~clinic ~~(RHC)~~, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, and federally qualified health center ~~(FQHC)~~ or a combination of the seven. For services beyond the established limit, extensions will be available if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the limit. Clients in the Child Health Services (EPSDT) Program are not benefit limited.

State of Arkansas *As Engrossed: H2/24/21 S3/17/21*
93rd General Assembly **A Bill**
Regular Session, 2021 HOUSE BILL 1254

By: Representatives Wardlaw, M. Gray, Dotson
By: Senator K. Hammer

For An Act To Be Entitled

AN ACT TO AUTHORIZE THE ARKANSAS MEDICAID PROGRAM TO RECOGNIZE AN ADVANCED PRACTICE REGISTERED NURSE AS A PRIMARY CARE PROVIDER; AND FOR OTHER PURPOSES.

Subtitle

TO AUTHORIZE THE ARKANSAS MEDICAID PROGRAM TO RECOGNIZE AN ADVANCED PRACTICE REGISTERED NURSE AS A PRIMARY CARE PROVIDER.

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

SECTION 1. Arkansas Code Title 20, Chapter 77, Subchapter 1, is amended to add an additional section to read as follows:

20-77-140. Primary care provider for Arkansas Medicaid Program — Advanced practice registered nurse.

(a)(1) The Arkansas Medicaid Program shall recognize an advanced practice registered nurse licensed by the Arkansas State Board of Nursing for all purposes as a primary care provider authorized to carry out the duties of a primary care case *manager, except as provided under subdivision (a)(3) of this section.*

(2) Purposes under subdivision (a)(1) of this section include without limitation:

(A) Being recognized as the initial healthcare provider in the Arkansas Medicaid Program;

(B) Performing initial diagnosis;

(C) Acting as the team leader of family practice professionals and the patient-centered medical home;

(D) Maintaining the medical records of a patient;

(E) Ordering laboratory tests and records management as needed for patient care;

(F) Providing preventive and periodic examinations within primary care;

(G) Referring a patient to a physician, a specialist, or a hospital when necessary; and

(H) Treating a patient within the scope of practice and *licensure of an advanced practice registered nurse.*

(3) Purposes under subdivision (a)(1) of this section does not include owning a patient-centered medical home.

(b) The program shall reimburse an advanced practice registered nurse:

(1) Not less than the current reimbursement rate for services performed within the scope of practice and licensure of the advanced practice registered *nurse; and*

(2) One hundred percent (100%) of the physician reimbursement rate for all out-of-pocket costs incurred by the advanced practice registered nurse such as the costs of laboratory tests, X-rays, and any additional tests ordered or conducted by the advanced practice registered *nurse.*

(c) A healthcare insurance policy in which the premiums are paid directly or indirectly by the program also shall recognize and reimburse an advanced practice registered nurse under subsections (a) and (b) of this section.

(d) This section does not increase the scope of practice or licensure of an advanced practice registered nurse.

/s/Wardlaw

APPROVED: 4/5/21