5. Physicians' Services

All physician services that an optometrist is legally authorized to perform are included in physicians' services under this plan and are reimbursed whether furnished by a physician or an optometrist.

A. Coverage for certain initial visits is limited to one visit per patient per physician per three (3) year period. This limitation applies to the following procedures:

New patient evaluation and management office or other outpatient services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

New patient evaluation and management home or custodial care services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

New patient evaluation and management preventive medicine services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

B. Coverage for an evaluation and management service with a corresponding CPT code of 99214 or 992 I 5 shall be limited to two (2) per recipient per year, per physician. If this limit is exceeded, then DMS will reimburse any such claim as a CPT code 99213 evaluation and management visit.

C. Outpatient psychiatric service procedures rendered by other than board- eligible and board-certified psychiatrists are limited to four (4) such procedures per patient per physician per twelve (12) month period.

D. Coverage for laboratory procedures performed in the physician's office is limited to those procedures for which the physician's office is CLIA certified with the exception of urinalysis performed by dipstick or reagent tablet only which shall not be payable as a separate service to physician providers. The fee for this, or comparable lab tests performed by reagent strip or tablet, excluding blood glucose, shall be included in the evaluation and management service reimbursement provided on the same date of service for the same provider.

The professional component of laboratory procedures performed by board certified pathologists in a hospital setting or an outpatient surgical clinic are covered so long as the physician has an agreement with the hospital or outpatient surgical clinic for the provision of laboratory procedures.

E. The cost of preparations used in injections is not considered a covered benefit, except for the following:

(1) The Rhogarn injection.
(2) Injectable antineoplastic chemotherapy administered to recipients with a malignancy diagnosis contained in the Association of Community Cancer Centers Compendia-Based Drug Bulletin, as adopted by Medicare.
(3) Depo Provera provided in the physician office setting.
(4) Penicillin G (up to 600,000 I.U.) and Ceftriaxone (250 mg.).
(5) Long acting injectable risperidone.
(6) An injectable, infused or inhaled drug or biological that is:
    a. Not typically self-administered;
    b. Not listed as a noncovered immunization or vaccine; and
    c. Requires special handling, storage, shipping, dosing or administration.

F. Coverage for standard treadmill stress test procedures are limited to three (3) per six (6) month period per recipient. If more than three (3) are billed within a six (6) month period, documentation justifying medical necessity shall be required.

G. Telephone contact between a physician and patient is not a covered service.

H. Coverage of a physician service is contingent upon direct physician/patient interaction except in the following cases:

(1) A service furnished by a resident under the medical direction of a teaching physician in accordance with 42 CFR 415.
(2) A service furnished by a physician assistant acting as agent of a supervising physician and performed within the physician assistant's scope of certification.

J. Reimbursement for induced abortions is provided when the physician certifies that the pregnancy was a result of rape or incest or the woman suffers from a physical disorder, injury or illness, including a life-endangering physical condition cause or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.

K. Any physician participating in the lock-in program will be paid for providing patient management services for each patient locked-in to him/her during the month.

L. Regional anesthesia (e.g., epidurals) for post-operative pain management shall be limited to one (1) service per day up to four (4) days maximum for the anesthesiologist.

M. Epidural injections of substances for control of chronic pain other than anesthetic, Contrast, or neurolytic solutions shall be limited to three (3) injections per six (6) month period per recipient.

N. Anesthesia Service limits are soft limits which means the service can be covered when medically necessary subject to prior authorization requirements described in material on file in the state agency.

O. Coverage for an evaluation and assessment service, provided by a physician or physician assistant with a corresponding CPT code of 99407 for tobacco cessation shall be limited to two (2) per recipient per year.

1. The evaluation and assessment service shall be:
   a. Performed face-to-face with the recipient;
   b. Be performed over a period of at least ten (10) minutes.

2. The evaluation and assessment service shall include:
   a. Asking the recipient about tobacco use;
   b. Advising the recipient to quit using tobacco;
   c. Assessing the recipient's readiness to quit using tobacco products
   d. Compiling a tobacco usage, medical, and psychosocial history of the recipient;
   e. Incorporating a review of the recipient's coping skills and barriers to quitting; and
   f. Providers obtaining of a signed and dated Tobacco Cessation Referral Form from the recipient declaring the recipient's intent to quit using tobacco.

P. Allergy testing, shots and allergy treatment for all Medicaid recipients, when medically necessary.

5. Physicians' Services

All physician services that an optometrist is legally authorized to perform are included in physicians' services under this plan and are reimbursed whether furnished by a physician or an optometrist.

A. Coverage for certain initial visits is limited to one visit per patient per physician per three (3) year period. This limitation applies to the following procedures:

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New patient evaluation and management preventive medicine services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

B. Coverage for an evaluation and management service with a corresponding CPT code of 99214 or 992 I 5 shall be limited to two (2) per recipient per year, per physician. If this limit is exceeded, then DMS will reimburse any such claim as a CPT code 99213 evaluation and management visit.

C. Outpatient psychiatric service procedures rendered by other than board- eligible and board-certified psychiatrists are limited to four (4) such procedures per patient per physician per twelve (12) month period.

D. Coverage for laboratory procedures performed in the physician's office is limited to those procedures for which the physician's office is CLIA certified with the exception of urinalysis performed by dipstick or reagent tablet only which shall not be payable as a separate service to physician providers. The fee for this, or comparable lab tests performed by reagent strip or tablet, excluding blood glucose, shall be included in the evaluation and management service reimbursement provided on the same date of service for the same provider.

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(6) An injectable, infused or inhaled drug or biological that is:
    a. Not typically self-administered;
    b. Not listed as a noncovered immunization or vaccine; and
    c. Requires special handling, storage, shipping, dosing or administration.

F. Coverage for standard treadmill stress test procedures are limited to three (3) per six (6) month period per recipient. If more than three (3) are billed within a six (6) month period, documentation justifying medical necessity shall be required.

G. Telephone contact between a physician and patient is not a covered service.

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K. Any physician participating in the lock-in program will be paid for providing patient management services for each patient locked-in to him/her during the month.

L. Regional anesthesia (e.g., epidurals) for post-operative pain management shall be limited to one (1) service per day up to four (4) days maximum for the anesthesiologist.

M. Epidural or spinal injections of substances for control of chronic pain other than anesthetic, contrast, or neurolytic solutions shall be limited to three (3) injections per six (6) month period per recipient.

N. Anesthesia Service limits are soft limits which means the service can be covered when medically necessary subject to prior authorization requirements described in material on file in the state agency.

O. Coverage for an evaluation and assessment service, provided by a physician or physician assistant with a corresponding CPT code of 99407 for tobacco cessation shall be limited to two (2) per recipient per calendar year.

1. The evaluation and assessment service shall be:
   a. Performed face-to-face with the recipient;
   b. Be performed over a period of at least ten (10) minutes.

2. The evaluation and assessment service shall include:
   a. Asking the recipient about tobacco use;
   b. Advising the recipient to quit using tobacco;
   c. Assessing the recipient's readiness to quit using tobacco products
   d. Compiling a tobacco usage, medical, and psychosocial history of the recipient;
   e. Incorporating a review of the recipient's coping skills and barriers to quitting; and
   f. Providers obtaining of a signed and dated Tobacco Cessation Referral Form from the recipient declaring the recipient's intent to quit using tobacco.

P. Allergy testing, shots and allergy treatment for all Medicaid recipients, when medically necessary.