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- 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.

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- J. Abortion services are reimbursable under the Medical Assistance Program only when the woman suffers from a physical disorder, physical injury or physical illness, including a life endangering physical condition caused or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed, or when the pregnancy is the result of an act of rape or incest.
- K. 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.
- L. 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.
- M. 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.
- N. 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 thirty (30) 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.