Limitations on Services

The service limitations described below reference services and benefits, which are described in greater detail, and provided in accordance with Part 3 of this State Plan:

2. Outpatient Services

On-island outpatient services will be provided by the governmentally-owned Commonwealth Healthcare Corporation's medical providers and its facilities at the: Commonwealth Health Center, Rota Health Center, Tinian Health Center, Public Health Clinics, and Transitional Living Center.

The only exception is if the outpatient services are not available at any of the Commonwealth Healthcare Corporation's facilities and prior authorization is obtained. Prior authorizations are granted when a certification from the Commonwealth Healthcare Corporation, stating that services are not available at the Commonwealth Healthcare Corporation, is attached to the request.

6.d Other Practitioner Services

Medical care or any other type remedial care, other than physician services, will be provided by licensed practitioners within the scope of practice defined under CNMI law.

A participating practitioner, public or private, must meet the following requirements:

a. CNMI-Licensed Clinical psychologist, nurse practitioner, or physician assistant
b. Signed agreement to participate with and abide by the rules and regulations of the Commonwealth of the Northern Mariana Islands Medicaid Program.

7. Home Health Services:

- Must be a Medicare-certified home health agency.
- Must be medically necessary.
- The fact that a provider has prescribed, recommended, or approved the services or items does not, in itself, make such services or items medically necessary or a covered service. The Medicaid Agency will make determination upon review of the claim and/or medical record.
- Home Health Services are provided in accordance with 42 CFR 440.70.
- These services include:

i) Nursing services, as defined in the State Nursing Practice Act, that are provided on a part-time or intermittent basis by a public or private home health agency or organization which meets the requirements for participation in Medicare.

ii) Home health aide services provided by a home health agency.

iii) Medical supplies, equipment and appliances suitable for use in the patient's residence.

iv) Physical therapy, occupational therapy, speech therapy and audiology services provided by a home health agency or by a facility licensed by the state to provide medical rehabilitation services.

- Therapy services are provided in accordance with 42 CFR 440.110..
- Physical therapy services provided by the Home health agency must be provided by a qualified physical therapist who is a graduate of a program of physical therapy approved by the both the Council of Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent and licensed to practice in the CNMI, in accordance with 42 CFR 440.120(c).
- Medical supplies and durable medical equipment other than wheelchairs must come from a Medicare-certified medical supplier

Wheelchairs:

- Must be prescribed by a licensed physician.
- Must have prior authorization by the Medicaid agency.
- Must be provided by a Medicare-certified DME supplier.
- Only one wheelchair is allowed every 5 years.
- Only standard, manually-operated wheelchairs are covered. Motorized chairs including its replacement parts are not covered.
- Repair and maintenance of wheelchair requires prior authorization by the Medicaid agency and must be due to normal wear and tear only.

10. Dental Services:

- Orthodontics, prosthetics, and root canal are not covered services.
  Coverage of oral surgery is limited to emergencies.
- Coverage is limited to age 19 and under, unless it is necessary for relief of pain and infection only.

12. Prescribed Drugs, Dentures, Prosthetic Devices and Eyeglasses:

12.a. Prescribed Drugs

- Must be prescribed by a licensed physician or practitioner as defined by federal and CNMI law.
- Coverage for brand-name medications is excluded when they are not listed in the CNMI Medicaid Drug Formulary or when an FDA approved A-rated generic equivalent is available. Prior approval is necessary if the drug is exempted.
- Limited to 30-day supply unless larger quantity is required for off-island travel. Any quantity larger than 30-day supply must have prior authorization by the Medicaid Agency.
- Experimental drugs or listed as "less than effective" drugs are not covered.
- Excluded Drugs, even if prescribed by a physician or medical provider, are Medications:
    - Tetrahydrocannabinol, Marinol or any form of cannibinoids,medical marijuana or marijuana alternative
    - For Weight loss
    - For Erectile dysfunction
    - For Promotion of fertility
    - For Gender reassignment
    - For Cosmetic Purposes
    - That do not have a National Drug Code (NDC)
- A limitation of six (6) filled prescriptions per month. The only exception is if the doctor has submitted to the Medicaid Agency a "Medical Plan of Care" and prior approval is granted.

12.c. Prosthetic Devices:

- Must be prescribed by a licensed physician in accordance with the 42 CFR 440.120(c).
- Repair and maintenance of prosthetic device or other medical equipment requires prior authorization by the Medicaid agency.
- Prosthetics, In accordance with 42 CFR 440.120(c), are used to artificially replace a missing portion of the body; prevent or correct physical deformity or malfunction; or support a weak or deformed portion of the body.

Hearing Aids:

- Must be prescribed by a certified audiologist or by a licensed physician in accordance with 42 CFR 440.110.
- Must have prior authorization by the Medicaid agency.

12.d. Eyeglasses:

- Must be prescribed by a licensed ophthalmologist or optometrist.
- Lenses may be for single vision or standard
- Tinted or coated lenses are not covered unless for individuals with aphakia.

- Only plastic frames are covered unless metal frames are less expensive.
- Contact lenses are not covered.
- Only one pair of eyeglasses will be covered every two years. There is a $100.00 LIMITATION ON COST OF frames.
- Lost or broken glasses for individuals over 19 will not be covered within the two years.
- REFRACTIVE PROCEDURES are not covered.

24.a.Ambulance Services:

Emergency Ambulance Services –

- Medicaid covers Emergency Ambulance services when provided by providers licensed by the state.
- The patient must be transported in an appropriate vehicle that has been inspected and issued a permit by the state.

Medical Transportation or Non-Emergency Ambulance Services

- Physician certification of medical necessity is required, whereas, the use of any other method of transportation would be hazardous to the patient's health, whether or not any other methods of transportation are available.
- No coverage when used for convenience of the patient, family, staff or doctor, or because other means of transportation were not available at the time. The patient's condition at the time of transport is the determining factor for a covered trip.
- Medicaid will not pay for non-emergency ambulance service unless the patient is unable to get out of bed without assistance, and unable to walk, and unable to sit in a chair or wheelchair, and/or that transportation by any other means would pose a hazard to the patient's health and these items must be documented ahead of time in patient records by a physician.